Self-Compassion Development: A Systematic Review of Autistic Experiences and an Exploration of how Adolescents Experiencing Mental Distress Make Sense of the Concept of Self-Compassion.

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Thesis submitted in partial fulfilment of the requirements of the University of Staffordshire for the degree of Doctorate in Clinical Psychology.

12th September 2025

Portfolio Abstract Word Count: 290

Literature Review Word Count (including abstract): 8417

Empirical Paper Word Count (including abstract): 8395

Executive Summary Word Count: 2561

Total Word Count: 19,663

Thesis Portfolio: Candidate Declaration

Title of degree programme	Professional Doctorate in Clinical Psychology
Candidate name	Charlotte A. Cochrane
Registration number	22042135
Initial date of registration	September 2022

Declaration and signature of candidate

I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.

I confirm that the decision to submit this thesis is my own.

I confirm that except where explicitly stated, the work has not been submitted for another academic award.

I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.

Signed:  Date: 20.07.2025

Acknowledgements

I would like to thank all the participants who shared their experiences and generously offered their time for this research. I extend my thanks to the youth panel, Think4Brum, who shared their ideas on what self-compassion means to them and ways to help participants to reflect on their own experiences.

Thank you to colleagues at the University of Staffordshire, especially, my research and clinical supervisors for your support and wisdom throughout the project. To Jo Heyes, thank you for your support whilst I developed my research proposal. I am grateful to Nicholas Davies for your academic guidance, and supervision space which helped me to focus and reflect. Judith Sutton, thank you for inspiring my passion in systemic approaches and working with children and young people. Sarah Taylor, thank you for encouraging my interest in the ways in which communities embody and cultivate compassion.

Thank you to Midlands Partnership University NHS Foundation Trust. In particular, I am grateful to South Staffordshire CAMHS for your dedication and support throughout the project.

I would also like to extend my gratitude to family and friends; your compassionate presence is forever cherished.

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Portfolio Abstract

This portfolio documents three papers, all aiming to understand experiences of self-compassion development. The first paper is a systematic literature review concerning autistic experiences of barriers to self-compassion. Nine empirical studies met inclusion criteria. Quantitative, qualitative and mixed methods studies were included, therefore, quality was appraised using the Mixed Methods Appraisal Tool. Narrative synthesis highlighted four barriers to self-compassion: backdraft, self-blame, camouflaging and emotion dysregulation.

Self-compassion exercises often triggered self-criticism and *soles of the feet* meditation resulted in negative physiological reactions. Camouflaging (masking of one's authentic experience) and self-blame appeared linked to social stigma and rejection. Correlations were observed between self-compassion and emotion regulation and self-compassion and camouflaging, though causal direction was not established.

The second paper reports an Interpretative Phenomenological Analysis study exploring adolescent experiences of self-compassion during mental distress. Seven participants aged 14-17 years-old were recruited via their Child and Adolescent Mental Health Services (CAMHS) keyworkers; six of whom identified as autistic. Participants spent two weeks photographing or creating artwork of what self-compassion meant to them.

Four group experiential themes were developed. Participants emphasised whether they accepted themselves or not. They prioritised relational experiences such as feeling understood by others, feeling held during their suffering, and sharing in laughter, playfulness and joy. Lastly, participants emphasised the way they treated themselves and others, and how they were treated in return. Methodological limitations resulted in less depth of understanding than hoped, however, findings illuminated a potentially unique adolescent emphasis on positive self-perception and shared positive experiences when conceptualising self-

compassion. This highlighted possible differences between adolescent and theoretical perspectives. Findings were most relevant to autistic adolescents accessing CAMHS. Implications of the findings are discussed. The third paper is an Executive Summary tailored towards participants, schools, and mental health clinicians.

Paper 1: Systematic Literature Review

Barriers to Self-Compassion: A Systematic Review of the Literature Concerning Autistic Populations.

Word Count: 8413

Paper 1 has been written in accordance with author guidelines for the Review Journal of Autism and Developmental Disorders (Appendix A).

Abstract

Existing literature suggests there is a negative correlation between self-compassion and mental distress. Self-compassion is considered to encompass a kindness to self, non-judgemental and balanced awareness of distress, and viewing suffering as part of the human experience. Interventions targeting self-compassion reduce transdiagnostic negative affect, particularly shame, which research suggests autistic individuals commonly experience. It is important to consider psycho-social barriers to self-compassion development to gain insights into moderating factors during self-compassion development. This review investigated the literature concerning barriers to self-compassion development, as experienced by autistic individuals experiencing mental distress.

Nine studies, consisting of quantitative, qualitative and mixed methods designs were appraised in this review. Each study reported on barriers to self-compassion, of which, a narrative synthesis depicted four key themes: backdraft, self-blame, camouflaging and emotion dysregulation. Results demonstrated self-criticism and negative physiological responses are common during self-compassion exercises. Frequent self-blame and efforts to camouflage autistic traits were portrayed within a complex context of social rejection and stigma associated with autism and distress. A relationship was also identified between emotion regulation and self-compassion levels; and camouflaging and self-compassion. However, direction and causation need to be established.

Results have implications for societal initiatives regarding autistic experiences which aim to reduce isolation, and to improve timeliness of autism assessments. The results indicate a use for therapeutic space to build self-understanding of cognitive and sensory profiles. Future research could investigate causality between self-compassion and camouflaging or emotion regulation. Furthermore, elaboration on specific self-compassion processes which impact emotion regulation would help. Increased practice-based evidence would facilitate

understanding of barriers to self-compassion alongside evaluating the effectiveness of compassion interventions. Validation of a fears of compassion scale with autistic populations may help establish replicable research, and more robust evidence regarding intervening with barriers.

Introduction

This review synthesises findings within the literature on barriers to self-compassion experienced by autistic populations. It is best practise to refer to individuals' preferred language to describe autistic experiences, given mixed preferences within autistic communities. For the purposes of this report, person-centred language will be adopted to describe autistic experiences, such as, 'autistic people', aligned with National Health Service (NHS) guidance (NHS England, n.d.).

The Autistic Spectrum

Autistic experiences are considered neurodevelopmental and typically first become apparent in early childhood, however, can manifest later if social demands impact coping. Autistic individuals can find neurotypical communication and reciprocal social interaction difficult and often engage with consistently restricted or repetitive behaviours (World Health Organisation, 2022).

Expanding conceptualisations sit within a neurodiverse 'umbrella' and stress the separation of autism from dysfunction (Bervoets & Hens, 2020). Autism is recognised as having heterogeneous traits, with genetic causes unidentified in 70% of cases (Masi et al., 2017). Functioning levels vary greatly, depending on autistic features. Historically, 'Asperger's Syndrome' described autism accompanied by increased functioning comparative to people with autism diagnoses. Currently, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) combines features of Asperger's and autism under the title, Autistic Spectrum Disorder (American Psychiatric Association, 2013). The DSM-5 assesses autism alongside support needs, and co-occurring difficulties. For example, studies indicate that 18% of people on the autistic spectrum also have learning disabilities (Lai et al., 2019).

Globally, autism prevalence is 1% however estimates vary between regions, reflecting sociodemographic factors, help seeking behaviours, service resources and differences in conceptualisations of autism (Zeidan et al., 2022). In the United Kingdom, 1.1% of the population aged 16 and older are estimated to be autistic, assessed by combined self-report and diagnosis (Brugha et al., 2011). For every known diagnosis, however, there are an approximated three people experiencing unidentified autistic experiences expected to meet thresholds for diagnosis (Baron-Cohen et al., 2009).

Across several studies males more frequently receive professional diagnosis of autism (Kogan et al., 2018; National Collaborating Centre for Mental Health, 2012). This is attributed to higher rates of camouflaging (strategies to hide social and communication difficulties), as well as under-reporting of autistic features across other genders (McQuaid et al., 2022; Scottish Intercollegiate Guidelines Network, 2016).

Autistic Experiences and Mental Distress

Global lifetime estimates of anxiety and depression in autistic adults (27% and 23%, respectively) meet clinical thresholds in severity and are substantially higher than in the general population (1-12% and 7% respectively) (Hollocks et al., 2019; Kessler et al., 2003; Kessler et al., 2012). This is consistent with estimates of cooccurring anxiety experienced by autistic children (39%), however diagnoses of cooccurring childhood depression are less common. Rates of cooccurring mental health and autism diagnoses vary greatly across the globe (15-79%). 41.5% of people in a UK autistic population received coexisting diagnoses; anxiety and depression being most prevalent (Houghton et al., 2018). However, conclusions cannot be drawn because of a lack of validated mental health measures concerning autistic communities. Furthermore, some autistic characteristics (such as, restrictive and repetitive behaviours) overlap with responses to severe anxiety (such as, compulsive behaviours) (Hollocks et al., 2019).

Internalised experiences of distress, such as self-criticism, more strongly mediate a relationship between autism and perceived quality of life, than a diagnosis itself (Andersen et al., 2023). High prevalence of psychological distress experienced by autistic people is in some instances associated with victimisation, and non-acceptance from others (Cage et al., 2018). These experiences increase the use of 'camouflaging behaviours', whereby an autistic person 'masks' their experiences to fit in with neurotypical norms (Perry et al., 2022).

Intervention

Evidence regarding effectiveness of psychological intervention for mental distress experienced by autistic people remains preliminary (Curnow et al., 2023). Curnow et al. (2023) highlight that studies are often low quality, with outcome measures not validated for autistic populations. They identify 31 systematic reviews, and no intervention is rated as evidence based, whilst several are deemed unsuitable. Acceptability of interventions in autistic populations is an identified area for continued research.

Autistic Experiences and Compassion

Compassion is defined within psychological literature as a sensitivity to suffering and motivation to address and alleviate it (Gilbert, 2014). It is a complex inter- and intra-personal experience, which exists within the relational context. Compassion is theorised to 'flow' in three directions: self to self, self to others, and others to self (Gilbert, 2016).

In western psychology, self-compassion is considered a concept of three elements (Neff, 2003):

A) Responding to oneself in the wake of mistakes or suffering with kindness and understanding, in place of harsh self-criticism.

B) Recognising suffering and mistakes as reflections of the human experience, rather than viewing them as isolating.

C) Non-judgementally observing painful thoughts and feelings, rather than becoming entangled with them.

Compassion Focused Therapy (CFT) aims to calm the body's natural stress response by inviting engagement with the para-sympathetic nervous system (Gilbert, 2009). The approach seeks to foster self-compassion development through experiential exercises, psychoeducation and compassionate relationships (Neff, 2003; Welford & Langmead, 2015). The development of self-compassion is considered effective within the general population at alleviating transdiagnostic negative affect such as persistent shame (Neff, 2009).

Autistic traits, operationalised using the Autism Spectrum Quotient, appear to be statistically significant predictors of lower self-compassion levels, although causation is not established and therefore conclusions cannot be drawn (Cai, Gibbs, Love, et al., 2023; Galvin et al., 2023). Research by autistic and non-autistic clinicians suggests that autistic individuals accessing mental health services can benefit from compassion-focused therapy (Mason et al., 2023; Galvin & Richards, 2023). However, studies investigating effectiveness of compassion-focused interventions on mental distress do not differentiate autistic experiences from within community samples (Wakelin et al., 2022). No review establishes effectiveness of compassion interventions in autistic populations, and insufficient intervention studies are available to merit conducting a systematic review.

Compassionate intervention involves mindfulness practice to develop skills observing distressing experiences in balanced awareness. Regarding autistic populations, emerging evidence suggests mindfulness therapies are effective in reducing severity of distress (Curnow et al., 2023; Cachia et al., 2016).

Barriers to Self-Compassion

A pivotal component of the use of compassion in therapeutic intervention is overcoming fears, blocks and resistances (FBRs) to compassion (Steindl et al., 2023). A meta-analysis concerning an adult general population established that barriers to compassion increase vulnerability to mental health difficulties (Kirby et al., 2019).

Research continues to explore how and why one actively resists engaging in compassionate experiences or behaviours (Gilbert, 2011). Fears of compassion derive from perceived negative consequences, such as appearing self-indulgent or being rejected. Resistances involve turning away from compassion when considered unhelpful, and blocks to compassion arise from a lack of resources (Steindl et al., 2023).

FBRs are often referred to in the CFT literature as ‘backdraft’. Backdraft refers to both emotional and physical discomfort that can be experienced when offering oneself increased compassion (Neff & Germer, 2022). Painful memories of cruelty and judgement can be triggered in response to fostering compassion. Backdraft is considered a natural part of healing, nevertheless, several theories highlight how backdraft can lead to therapeutic discomfort specifically from an autistic perspective during compassion-focused therapies, as explained below.

Overwhelming Affect

Past aversive emotional memories can be triggered in response to acts of compassion which can feel overly distressing (Gilbert et al., 2014). Distressing memories for autistic individuals with mental health difficulties may be exacerbated by internalised stigma (Riebel et al., 2023). Some autistic people can also feel intense emotional empathy and adopt the negative emotions of others, leading to overwhelm (Smith, 2009).

Furthermore, autistic individuals may experience difficulties regulating emotion (Cai, Gibbs, Love, et al., 2023). Emotion regulation involves individuals consciously, or unconsciously, moderating their own positive and negative affect (Gross, 1998). This may be exacerbated by cognitive challenges when problem solving distressing situations due to individual differences in brain networks controlling emotion regulation and executive function (Baron-Cohen, 2004; Minshew & Keller, 2010).

Alexithymia

Alexithymia describes difficulties identifying, understanding and expressing emotions. Autistic participants who do not label their emotions and who experience intense negative affect display higher rates of emotion dysregulation (Costache et al., 2024). Challenges recognising bodily sensations also exacerbate alexithymia. This may hinder observation of difficult emotions, the mindfulness component of self-compassion development.

Perspective Taking

Autistic individuals can struggle to understand perspectives of others, namely, cognitive empathy (Baron-Cohen, 2004). Cognitive empathy can be a significant factor in compassion development but is not essential (Vieten et al., 2024). Nonetheless, compassion interventions often heavily rely on perspective taking, for example, to view experiences from the perspective of a ‘compassionate other’. Compassion can also be driven by affective empathy, which research suggests autistic individuals experience more commonly than cognitive empathy (Fatima & Babu, 2023). Above all, compassion moves beyond empathy by not only understanding there is suffering but also having a desire to alleviate it. However, autistic individuals may struggle to cognitively make sense of distress.

Self-Criticism and Shame

Autistic adults can be self-critical and prone to shame due to invalidating life experiences and frustrations with sensory overload in environments designed for neurotypical individuals (Acland & Spain, 2022). Galvin & Richards (2023) theorise that lack of compassion from a neurotypical society leads to vulnerabilities in autistic populations concerning internalised negative messages about the self. Galvin & Richards (2023) evidence lower levels of self-compassion, incorporating a self-kindness measurement, amongst autistic adults compared to non-autistic adults. Additionally, the compassionate brain theory posits that autistic adults experience more compassion for others than for themselves (Galvin, 2023).

Aims and Rationale

Evidence suggests compassion interventions may support individuals experiencing transdiagnostic negative affect, such as shame (Craig et al., 2020). This is especially relevant for autistic individuals experiencing difficulties with mental distress (Riebel et al., 2024). However, commonly used compassion exercises such as perspective taking and imagery production were developed within general community populations and may not tailor to the neurodiverse abilities of autistic individuals (Baron-Cohen, 2004).

Additionally, a recent review highlights the need to further consider barriers arising in compassion-focused therapies from the perspective of autistic populations (Curnow et al., 2023). To fully utilise compassion approaches, clinicians need to better understand FBRs and backdraft concerning self-compassion, from an autistic experience. A review on the barriers to self-compassion in autistic populations is therefore warranted.

This review will identify areas for further research and clinical implications for navigating barriers to self-compassion. Accordingly, the literature review aims to answer the

question: What are the barriers to developing self-compassion from the perspective of individuals on the autistic spectrum who are experiencing mental distress?

Method

Search Strategy

The PCC (population, concept, and context) framework was adopted to define eligibility criteria (Pollock et al., 2023). A systematic search strategy was completed in August 2024. Databases searched included: Google Scholar, Education Resources Information Centre, Education Research Complete, MEDLINE, CINAHL Plus, American Psychological Association (APA) PsychInfo, and APA PsycArticles. To manage a high volume of results, the first 200 results from Google Scholar were considered for the purpose of this review (Haddaway et al., 2015). Studies conducted and published in any country were included. However, papers needed to be written in English as no translation resources were available. Studies were only included if the full paper was available. Except for dissertation literature (see below), only published, peer-reviewed studies were included to prioritise study quality.

Publication Bias

Dissertation literature was searched using ProQuest to mitigate publication bias, whereby published work biases positive findings (Vasilev, 2013). One additional study was identified for inclusion in this way.

Search Terminology

Conceptual boundaries differentiating backdraft and FBRs to self-compassion are not clearly defined in literature (Cai, 2024). An initial scope including the search terms, ‘barrier*’, ‘blocks’ and ‘resistances’ did not identify relevant papers. Navigating beyond this

terminology to ‘barriers’ of self-compassion allowed investigation into both concepts, alongside any unestablished factors.

Search terms were used which captured all studies exploring self-compassion within autistic communities. The inclusion criteria were utilised to thereafter facilitate in-depth screening concerning barriers to self-compassion and presence of co-occurring mental distress.

Search terms therefore included: 1) (Autis* OR Asperger* OR ASC OR Autistic Spectrum Condition* OR ASD OR Autistic Spectrum Disorder*) AND (Compassion OR kindness OR CFT OR "Compassion focused therapy" OR "common humanity"); and 2) (Autis* OR Asperger* OR ASC OR Autistic Spectrum Condition* OR ASD OR Autistic Spectrum Disorder*) AND “fear* of compassion”.

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria are conveyed below. If eligible studies explored additional subject matters, only findings relevant to the review were synthesised. Individuals who self-reported as autistic were included to account for delays in professional diagnoses (Lai & Baron-Cohen, 2015).

Inclusion criteria:

- Published in a peer-reviewed journal or unpublished dissertation.
- Published in English.
- Included a defined autistic population (self-identified or formal diagnosis).
- Study findings or data collection reported experiences of mental distress.
- Declared a focus on self-compassion by a) use of self-compassion as an intervention component b) a self-compassion measurement c) a concept definition.

- Study findings or methodology reported barriers to self-compassion development.

Exclusion criteria:

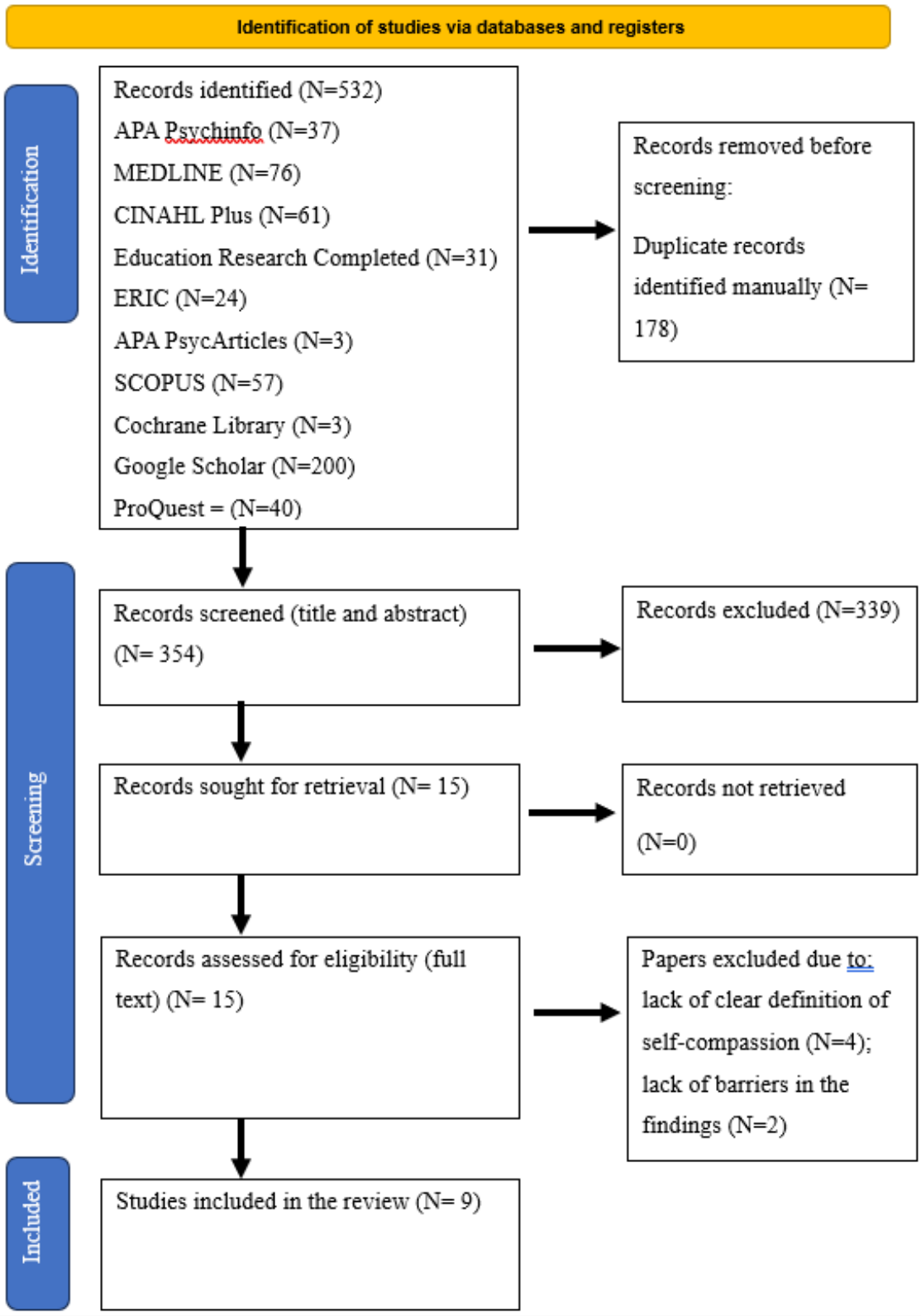
- The experience of family / caregiver/ educators.
- Not an empirical paper or dissertation.
- Presence of a learning disability, due to the complexity of confounding factors in the review.

Selection Process

The literature selection process is presented in the PRISMA flow chart (figure 1) (Page et al., 2021). Following the initial search, duplicates were removed, and titles and abstracts were screened using the inclusion and exclusion criteria. Full texts of the remaining 15 articles were screened. Six papers were excluded in total; four due to having no self-compassion focus and two which did not report barriers to self-compassion. Two papers did not quantitatively measure mental distress, however reported mental distress in qualitative findings and were therefore included (Hartley et al., 2022; Wilson et al., 2022). Nine papers were included in the final review.

Figure 1

Prisma Flow Chart (Page et al., 2021)



Results

Data Extraction

A data extraction table of population, intervention, comparison and outcome factors was developed (Appendix B). This identified patterns and distinctions regarding barriers to self-compassion (Booth et al., 2016). Factors offering insight into barriers of self-compassion development were recorded alongside study limitations.

Participant and Study Characteristics

The final studies consisted of five quantitative non-randomised studies, one mixed method study and three qualitative studies (table 1).

Table 1

Table of Study Characteristics

Author, Year & Country	**Methodology**	**Autistic participant characteristics**				**Barriers to self-compassion**
		Number (of)	**Ethnicity**	**Age (Years)**	**Gender**	
			Non-randomised quantitative			
Cai et al., 2024, Australia	- Intervention (pilot study) - Survey	N = 39	-White (N = 38) -Mixed (N = 1)	18+ only Mean = 45.28 SD = 11.92).	female N = 28 (72%) male N = 5 (13%)	-Significant increase in self-compassion post-intervention however backdraft when practising self-compassion (unpleasant emotions and self-criticism) which reduced with practise.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
	- Paired T-test pre- & post-intervention				non-binary or agender N = 6 (15%)	-Significant reduction in emotion regulation problems. -Significant decrease in depression and anxiety. -Negative physiological reactions to somatic exercise, *soles of the feet*.
Riebel et al., 2024 France	- Intervention - Single case pre-experimental design (A-B)	N = 1	Unreported	41	male	-Social stigma about autism. -Internalised self as abnormal. -Backdraft. -Confronting fears through experiential exercises.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
Cai et al., 2023 Australia	- Survey - Correlation - Regression	N = 153	White N = 126(82%) Asian N = 10 (7%) Multiethnicity N = 9 (6%) Pacific Islander N = 8 (5%) Hispanic N = 6 (4%) African N = 4 (3%) Aboriginal N = 2 (1%) Torres Strait Islander N = 2 (1%)	Range = 18-75 Mean = 35.70 SD = 12.62	female N = 97 (63%) male N = 41 (27%) non-binary N = 14 (9%) other N = 1 (1%)	-Self-compassion weakly and negatively associated with anxiety and depression. - Self-compassion strongly and negatively correlated with emotion dysregulation. -Emotion regulation as a statistically significant mediator of the relationship between self-compassion and anxiety, b = -0.18, 95% CI (-0.25 to -0.12). -Emotion regulation mediated the relationship between self-compassion and depression, R2 = 0.43, F(1,150) = 113.14, p < 0.001, & the indirect effect was also

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
			Middle Eastern N = 2 (1%)			statistically significant, b = -0.14, 95% CI (-0.20 to -0.09).
Galvin et al., 2024 UK	- Survey - Correlational - 12-month three-wave cross lagged panel design.	N = 294	White (78%) Asian (10%) Black (9%) Mixed (2%)	Range = 18–65 Mean = 30.53 SD = 12.57	N = 142 male N = 152 female	-People with higher autistic traits camouflaged traits more in social situations, associated with reduced self-compassion. -A moderate and negative correlation observed between camouflaging and self-compassion (rpartial = -0.483, $p < 0.001$). - Compared to self-compassion to camouflaging indirect pathway, stronger associations were observed for a camouflaging to self-compassion indirect

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
						pathway (range b = 0.06–0.09), accounting for between 20% and 23% of the total effect of autistic traits on mental health outcomes.
Galvin et al., 2023 UK	- Survey - Cross sectional - Longitudinal	N = 228 at T1, N = 156 at T2, N = 165 at T3.	White (87.3%) Asian/Asian British (3.9%) Mixed (3.9%) Black/Black British (3.1%) Middle/ Near Eastern (1.3%) Hispanic or Latino (0.4%).	18+ At baseline (T1), Autistic participants Range = 18–60 Mean = 30.5 SD = 9.47	unreported	-Low levels of self-compassion predicted later anxiety and depression across all models and at all assessment points. Earlier anxiety and depression did not predict subsequent self-compassion. -Autistic traits predicted later reduced self-compassion.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
Mixed methods						
Cai, Gibbs, Love, et al., 2023 Australia	- Survey - Multiple regression - Qualitative interviews	Survey N = 153 Interviews: N = 11	White N = 126 Asian N = 10 Multiethnicity N = 9 Pacific Islander N = 8 Hispanic N = 6 Africa N = 4 Aboriginal N = 2 Torres Strait Islander N = 2 Middle Eastern N = 2	Range = 18 to 75 Mean = 35.70 SD = 12.62	female N = 97 (63%) male N=41 (27%) non-binary N=14 (9%) other N=1 (1%)	- The total variance in self-compassion explained by age, highest level of education and autism was 24%, F (3, 149) = 15.26, p<.001. Age (beta=−0.16, p =.042) and autism traits (beta=−0.34, p<.001) were statistically significant predictors of self-compassion. - Increased age was a significant negative predictor of self-compassion in autistic adults. There was a positive trend with non-autistic adults, however age was not

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
			Multiethnicity N = 9			significantly associated with self-compassion. - Self-compassion levels of autistic adults were significantly lower than those of non-autistic adults. - Autism traits were negatively associated with self-compassion levels in autistic and non-autistic samples. Qualitative barriers: - Self-criticism in social and work contexts. - Strong negative emotion towards themselves, when making mistakes or not meeting self-standards.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
						- Over identification with emotions - Disconnection from non-autistic people, experiencing inner experiences as not shared with individuals not on the spectrum -Challenges observing own thoughts and feelings
				Qualitative		
Edwards et al., 2024 Australia	- Semi-structured interviews	N = 39	White N = 38 Mixed N = 1	18+ Mean = 45.28 SD age = 11.92	female N = 28 male N = 5 non-binary or	- Backdraft when practising self-compassion (difficult emotions and painful memories). - High self-criticism compared to how participants treated others.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
	- Reflexive Thematic Analysis				agender N = 6	- Struggling to identify own feelings. - Difficulty keeping focus on the exercises. - Difficulty maintaining practice due to mental effort. - *Soles of the feet* not appropriate for sensory profiles. - Negative comparisons of self to people in the intervention lived experience videos. - Lack of reassurance that they are 'on the right track' with the exercises. - Prescriptive exercises, lack of flexibility to discover which exercises suit them.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
Hartley, 2022, UK	- Semi-structured interviews - Reflexive Thematic Analysis	N = 15	White British N = 13 White other N = 2	Range = 20-69 Mean and SD unreported	female N = 9 (60%) male N = 5 (33%) self-identified as neutral N = 1 (7%)	- Non-acceptance from others throughout life course. - Blaming self for communication misunderstandings and putting pressure on self to change and fit in. - Others not understanding autistic communication. - Late diagnosis associated with reduced self-understanding. - Difficulties recognising emotions in the moment. - Difficulties interpreting emotions.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
						- Feeling their own difficulties were unique or more severe than others (autistic or nonautistic). - Other autistic people hiding their struggles making it difficult to recognise they are not alone. - Overwhelming emotional empathy. - Sacrificing one's own needs. - Ruminating on flaws. - Other people modelling criticism and disapproval. - Lack of care/support after making a mistake.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
						- Lack of kindness from others. - Loneliness in social withdrawal. - Perceiving failings as truths. - Participants judging their behaviours, in a binary way, as right or wrong - Ruminating on mistakes.
Wilson et al., 2022 UK	- Semi-structured interviews - Interpretative Phenomenological Analysis	N = 11	White British N = 10 White N = 1	Range = 35-69 Mean and SD unreported	cisgender, female N = 11	- Autism as misunderstood and stereotyped. - Feeling different from / wrong compared to / less than others in society. - Difficulties navigating social rules. - Pressure to conform. - Negative messages about autism through Applied Behavioural Analysis.

Author, Year & Country	Methodology	Autistic participant characteristics				Barriers to self-compassion
		Number (of)	Ethnicity	Age (Years)	Gender	
						- Rejecting views of others. - Experience of victimisation. - Interpersonal difficulties. - Seeking external validation. - Masking - Isolation - Fear of self-compassion as over-indulgent - 'Striving traits' to be accepted by society. - Late diagnosis (in adulthood).

Overview of Studies

All nine studies recruited adults with clinically significant autistic traits or diagnoses, and most participants were White females aged between 31- 45 years. Five quantitative non-randomised studies were included. Two were intervention studies (Riebel et al., 2024; Cai et al., 2024). Riebel et al (2024) adopted individualised CFT, whilst Cai et al. (2024) utilised a self-guided, program for autistic adults, namely, the Aspect Self-Compassion Program for Autistic Adults (ASPAA). These both demonstrated increases in self-compassion post-intervention. Each investigated acceptability of the intervention, however, did not meet Mixed Method Appraisal Tool (MMAT) criteria for mixed-methods design. Both papers identified barriers to self-compassion through intervention processes.

Two quantitative non-randomised studies utilised cross-sectional designs and highlighted variables impacting self-compassion scores (Galvin et al., 2024; Cai et al., 2023). These included the independent variables of camouflaging (Galvin et al., 2024), emotion regulation and mental distress (Cai et al., 2023). The fifth non-randomised study analysed whether mental distress and autistic traits predicted self-compassion levels across a 12-month period (Galvin et al., 2023).

Cai, Gibbs, Love, et al. (2023) conducted a mixed methods investigation into self-compassion experiences. This included reflexive thematic analysis of eleven interviews, and linear regression investigating demographic predictors of self-compassion.

Edwards et al. (2024) qualitatively explored experiences of ASPAA; the intervention quantitatively evaluated in the aforementioned study (Cai et al., 2024). Hartley (2022) qualitatively explored experiences of self-kindness, including helpful and hindering factors.

The third qualitative paper focused on women's experiences of self-compassion following autism diagnoses (Wilson et al., 2022).

Regarding self-compassion levels of autistic participants, seven studies provided mean Self Compassion Scale (SCS) scores. SCS scores between 1.0-2.49 are considered low, 2.5-3.5 as moderate and 3.51-5.0 as high (Neff, 2003). Six studies reported low SCS scores pre-intervention; means ranged from 2.14 to 2.35. One study reported a moderate mean score of 2.5 (Cai et al., 2023).

Pertaining to mental distress, only one study recruited from a mental health service (Riebel et al., 2024), however, six studies measured anxiety and reported mean scores above the clinical cut off (Galvin et al., 2024; Galvin et al., 2023; Cai et al., 2024; Cai et al., 2023; Cai, Gibbs, Love, et al., 2023, Edwards et al., 2024). Five studies reported mean depression scores above clinical cut off (Galvin et al., 2024; Cai et al., 2024; Cai et al., 2023; Cai, Gibbs, Love, et al., 2023, Edwards et al., 2024). One study reported a mean depression score which was borderline clinical threshold (Galvin et al., 2023). Two qualitative studies reported mental distress in the findings (Wilson et al., 2022; Hartley et al., 2022).

Quality Appraisal

Papers were considered relevant if they satisfied at least 60% of the Mixed Methods Appraisal Tool (MMAT) criteria. The MMAT can efficiently appraise qualitative, quantitative, and mixed methods studies (Hong et al., 2018; Pace et al., 2012). The MMAT is a valid, reliable measure, with 'substantial' (0.72) rater agreement across overall quality scores (Pace et al., 2012).

Each quality criteria were assessed against three response options: 'Yes' meaning the criterion is met, 'No' meaning the criterion is not met, and 'Can't tell' whereby there is not

enough information to judge (Appendix C). Where criteria were partially met, ‘no’ was assigned to establish consistency of the appraisal.

Hong et al (2018) encourage interpretation of appraisal, rather than assignment of overall quality scores; both were adopted for the purpose of this review. Overall quality scores used a star system where five stars represents 100% of the criteria met (Hong et al., 2018). Quality ratings ranged from 60-100%

Publication Bias

Negative findings can be underrepresented in peer reviewed literature (Fanelli, 2012). Dissertation literature was searched to account for this, identifying one of the included papers (Hartley, 2022). Published research prioritises evaluation of effectiveness of compassion focused therapies across clinical mental health populations (Petrocchi et al., 2024). Recent studies investigated fears of compassion within community samples utilising the fears of compassion scale (FCS) (Steindl et al., 2023; Matos et al., 2023; Gilbert et al., 2014). No papers identified in this review with autistic populations adopted the fears of compassion scale. This suggested the area is less researched with autistic populations.

Design and Methodology

Overall, the outcomes from the MMAT quality appraisal reflected the rigor of peer reviewed papers. The main quality considerations involved risk of sampling bias and validity of measures when utilised with autistic populations.

Participant Representation.

Recruitment excluded participants without online access or autism support networks (Cai, Gibbs, Love, et al., 2023; Galvin et al., 2024; Galvin et al., 2023; Cai et al., 2024; Cai et al., 2023; Edwards et al., 2024; & Wilson et al., 2022) or individuals who had not expressed interest in taking part in autism research (Hartley, 2022). However, recruitment also targeted autism organisations which reduced sampling bias and was reflected in a diverse range of ages and educational attainment (Cai et al., 2024; Cai et al., 2023; Cai, Gibbs, Love, et al., 2023; Wilson et al., 2022).

Four studies recruited individuals with autism diagnoses (Riebel et al., 2024; Hartley 2022; Wilson et al., 2022; Edwards et al., 2024). Five studies risked interpretation biases by

relying on self-reported diagnoses (Gernsbacher et al., 2017). Additionally, Galvin et al. (2024) offered compensation above the UK living wage. This may have encouraged false reporting to meet the inclusion criteria. Interpretation bias was offset in four studies by reporting mean scores above clinical cut off on the Autism Quotient-short (AQ-short) (Galvin et al., 2023; Cai et al., 2023; Cai et al., 2024; Cai, Gibbs, Love, et al., 2023). Although autistic traits may represent characteristics separate to autism (Mottron & Bzdok, 2020), it was necessary to include these studies to account for delays in receiving autism diagnoses (Lai & Baron-Cohen, 2015).

One study failed to report comparable AQ-scores, by changing the recommended scoring method (Galvin et al., 2024). However, the target variable, camouflaging, was captured using the Camouflaging Autistic Traits Questionnaire (CAT-Q), a validated and reliable measure with autistic populations.

Additionally, six studies recruited mostly females which was not reflective of the population in autism diagnostic services, where males' diagnoses are more common (Wilson et al., 2022; Edwards, 2024; Hartley, 2022; Cai et al., 2024; Cai et al., 2023; Cai, Gibbs, Love, et al., 2023).

Measures.

Six of the studies utilised quantitative, self-report measures, and research suggests autistic and non-autistic individuals may interpret question wording on self-report scales differently to each other (Pelton et al., 2020). Each study adopted the SCS to measure self-compassion. Howes et al. (2021) established an excellent internal consistency using the SCS with autistic participants ($\alpha = 0.935$) (Howes et al., 2021). The SCS, however, may be subject to social desirability, reducing validity of results (Furnham & Henderson, 1982).

The reliability of outcome measures pertaining to mental distress when measured with autistic populations have been systematically reviewed (Kim & Lecavalier, 2022). Of seven self-report measures utilised across studies in this review, only two are evaluated in Kim & Lecavalier's review: the Hospital Anxiety and Depression Scale (HADS) and the Patient Health Questionnaire-9 (PHQ-9).

The HADS measures both anxiety and depression and was found to have good internal consistency for anxiety ($\alpha = 0.84$) and poor internal consistency for depression ($\alpha = 0.65$). The result for anxiety was corroborated by Galvin et al. (2023) who established HADS internal consistency of ($\alpha = 0.86$), however they also report good internal consistency for depression ($\alpha = 0.80$). The PHQ-9 measures depression and its total score was considered to have excellent internal consistency ($\alpha = 0.91$) and fair to good for the subdomains of cognitive affective ($\alpha = 0.89$) and somatic ($\alpha = 0.79$) (Kim & Lecavalier, 2022).

Galvin et al. (2024) established an excellent score of internal consistency for the Liebowitz Social Anxiety Scale adopted with autistic people ($\alpha =0.972$). The two studies adopting the Difficulties in Emotion Regulation Scale did not report internal consistency (Cai et al, 2022; Cai et al, 2023). This was, however, validated with good internal consistency, ranging from $\alpha = 0.80$ to $\alpha = 0.90$ across factors in the scale, when adopted with autistic adults in a different study (Mcvey et al., 2022).

Three studies utilising the Generalised Anxiety Disorder Dimension Scale did not report internal consistency when adopted with autistic populations (Cai et al, 2024; Cia et al, 2023; Cai et al, 2022). A recent study, nevertheless, established good internal consistency ($\alpha =.90$).

Riebel et al. (2024) utilised the Internalised Stigma of Mental Illness Scale (ISMI-9) however do not report internal consistency. Riebel et al (2025) established an acceptable

internal consistency score (α = 0.76) in their use of the ISMI-9, however they adapted the scale to ask about internalised stigma of autism, rather than mental illness. Neither Cai et al. (2024) nor Cai, Gibbs, Love, et al. (2023) report Cronbach's Alpha for the Warwick-Edinburgh Mental Wellbeing Scale, however a previous study reports high consistency with an autistic sample (α = 0.92) (Muniandy et al., 2022).

Galvin et al. (2024) adopted The Camouflaging Autistic Traits-Questionnaire (CAT-Q) which reliably measured camouflaging traits, with good internal consistency (α=.939). The CAT-Q was developed from autistic experiences including compensatory behaviours to navigate communication difficulties, and hiding autistic characteristics (Hull et al., 2019).

Most of the quantitative studies did not tailor the scales to an autistic audience which could decrease validity of the measurement; however, previous studies establish internal consistencies ranging from acceptable to excellent when the scales were used with autistic populations. Evidence of reliability is limited regarding the ISMI-9, and careful consideration of construct validity is warranted when interpreting results.

Data Completion.

All five non-randomised studies, and the mixed methods study, reported complete outcome data with response rates of 80% or higher. Galvin et al. (2023) maintained high response rates across three time points (N = 228 at T1, 156 at T2, and 165 at T3), allowing more reliable results.

Confounders and Intended Intervention.

All study methodologies aligned with clear research questions. Cross-sectional studies and the longitudinal study all had adequate sample size to meet statistical power, and survey attrition did not impact results. Given that previous research suggested levels of self-compassion may differ accordingly, age and sex were accounted for as confounders in two

cases (Galvin et al., 2023; Galvin et al., 2024). Galvin et al. (2023) completed a longitudinal analysis, which further mitigated risk of confounders. Galvin et al. (2024) checked for collinearity and outliers when conducting Pearson's correlations.

Cai et al. (2023) did not account for age or sex in their analysis. Convenience sampling resulted in 63% of participants identifying as female, whereby the diagnosed autistic population consists of a gender ratio of one female, per four males (National Collaborating Centre for Mental Health, 2012). Mostly females (72%) participated in the study by Cai et al. (2024); and the researchers did not attempt to control for gender in their analysis. Paired T-tests pre and post intervention were conducted, without randomisation or a control condition.

A clear baseline was not established in the single case experimental A-B. This meant changes in outcome measures could not be attributed to the intervention phase only and may have been influence by confounding factors (Riebel et al., 2024).

Qualitative Methods.

All three qualitative studies, and the qualitative component of the mixed methods study, met 100% of the criteria. The papers recruited participants suitable for their research aims. Data collection methods were appropriate: Edwards et al. (2024) used qualitative surveys and weekly check-ins, and the others adopted semi-structured interviews. Only Edwards et al. (2024) included autistic researchers in the design and analysis, which enhanced applicability of the findings. Findings may therefore be limited by misunderstandings in communication, namely, the double empathy problem (Jones et al., 2024; Livingston et al., 2024).

Nonetheless, all studies ensured robust interpretations through team discussions or reflexive diaries. All papers aligned with phenomenology and constructivism, addressing reflexivity, though key implications of researcher reflexivity on the research findings were not

always fully detailed in the papers. Qualitative themes were developed with supporting data and a coherent narrative. Trustworthiness was considered across all studies, but generalizability was limited due to the idiographic approach of methodology.

Synthesis

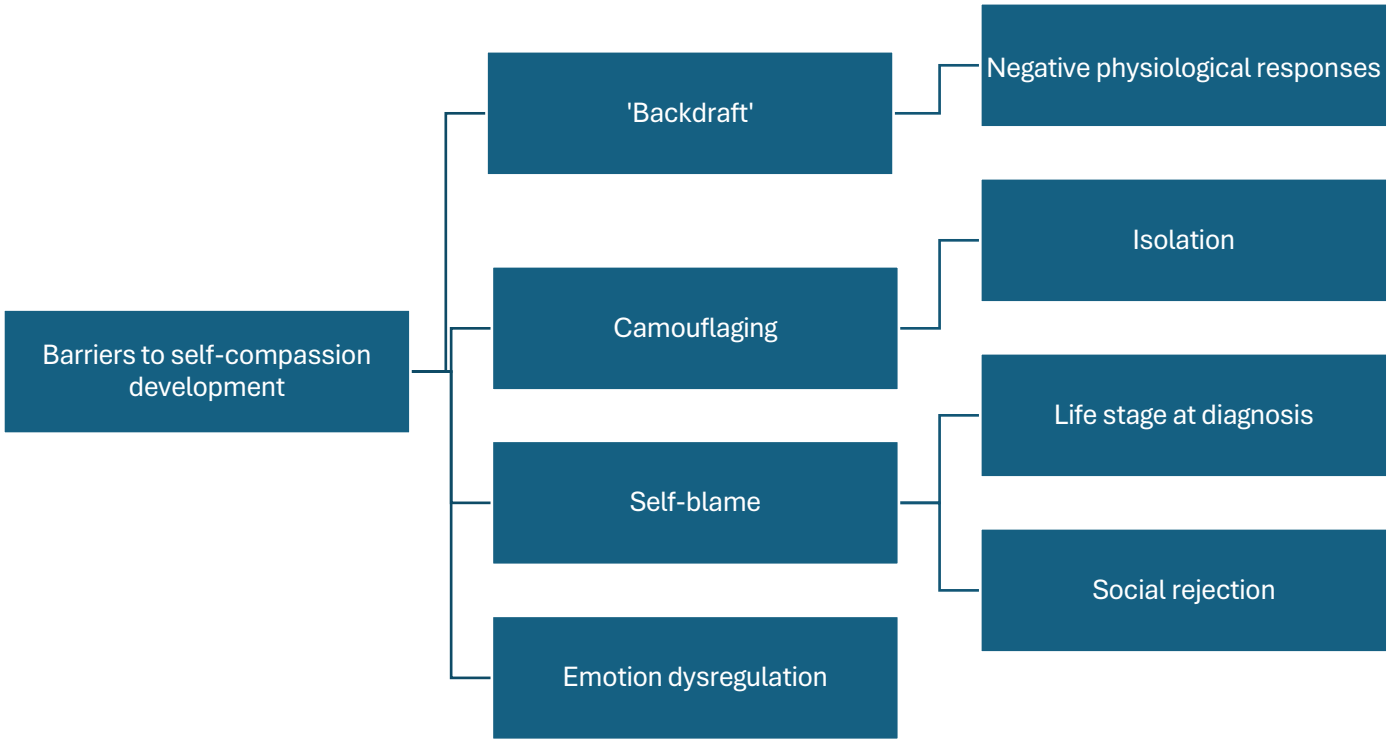
Narrative synthesis was adopted to inductively investigate the barriers to self-compassion (Popay et al., 2006). Narrative synthesis is a recognised method to synthesise findings from heterogenous studies; exploring similarities and differences across multiple quantitative, mixed-methods and qualitative papers (Popay et al., 2006).

Patterns of data regarding barriers to self-compassion were identified. Throughout this process, self-compassion was defined by psychological theory as: kindness to self, common humanity, and holding painful experiences in balanced awareness (Neff, 2009). Common humanity was understood as, 'seeing one's experiences as part of the larger human experience rather than as separating and isolating' (Neff, 2009). Patterns were considered significant if repeated across two or more papers.

Preliminary synthesis organised the data into a summary table capturing key barriers alongside study characteristics (table 1). Secondly, factors regarding barriers to self-compassion, present across a minimum of two papers, were visualised using concept mapping (figure 2). These relationships were then narratively synthesised, accounting for quality of the research included. Finally, the robustness of the synthesis itself was appraised.

Figure 2

Concept Map



Backdraft

Three papers highlighted how backdraft was experienced when participants were guided to be compassionate to themselves (Cai et al., 2024; Edwards et al., 2024; Riebel et al., 2024). Backdraft occurred in response to compassionate letter writing and the loving-kindness meditation, which both required accessing a wise and caring self and offering kindness to the part of oneself who is suffering. Cai et al. (2024) quantified that 54% of participants experienced backdraft in the form of self-criticism. Riebel et al. (2024) highlighted backdraft during interpersonal role plays, chair work and embodiment practice. This was related to the participant's fear, "others will make fun of me".

Two papers showed increases in self-compassion following intervention, despite backdraft reports (Cai et al., 2024; Riebel et al., 2024). Riebel et al. (2024) facilitated twenty individual sessions of approximately one hour in length, whilst Cai et al. (2024) offered a self-guided online programme with only weekly 'check-ins' with a facilitator. The contexts are therefore inconsistent. Additionally, Riebel et al.'s (2024) participant completed Dialectical Behavioural Therapy (DBT) two years prior to CFT. DBT reportedly reduced emotion dysregulation for the participant which may have supported them to cope with backdraft.

Physiological Response.

Two papers highlighted negative physiological responses to *soles of the feet* practice (Cai et al., 2024; Edwards et al., 2024). Cai et al. (2024) denoted physical discomfort which for some resulted in anger, or stress about doing the exercise incorrectly. One participant interviewed about the Aspect Self-compassion Program for Autistic Adults (ASPAA) described *soles of the feet* practice as "too weird" whilst another stated it was a sensory trigger (Edwards et al., 2024). Participants who struggled with physiological responses to *soles of*

the feet practice stopped practising the meditation, suggesting somatic approaches to developing self-compassion need to be adaptable to sensory needs.

Camouflaging

Contrary to developing a sense of common humanity, Wilson et al. (2022) and Hartley (2024) identified participants felt "lesser than" others, "wrong" and a "pressure to fit in", which resulted in masking of authentic experiences. Hartley (2024) identified examples such as hiding tics or hand-flapping, rehearsing conversations, or staying quiet and copying clothing preferences of others. Participants camouflaged to avoid negative responses from others, such as bullying. However, camouflaging was experienced as tiring and frustrating, and reduced kindness towards oneself. Galvin et al. (2024) demonstrated a bidirectional relationship between camouflaging and self-compassion, suggesting camouflaging is a potential key factor affecting self-compassion development.

Isolation.

A sense of isolation was exacerbated by camouflaging. This included others in the autistic community masking their authentic selves. Feelings of isolation diminished participants' sense of common humanity. Three papers highlighted participants felt isolated when viewing their experiences as unique and different to non-autistic individuals (Hartley et al., 2022; Wilson et al., 2022; Cai, Gibbs, Love, et al., 2023).

Self-Blame

Three papers portrayed self-blame as a dominant difficulty following social situations (Cai, Gibbs, Love, et al., 2023; Wilson et al., 2022; Hartley, 2024). Cai, Gibbs, Love, et al. (2023) highlighted participants were self-critical regarding "doing the wrong things" and frustrated with themselves when finding social situations too overwhelming. Edwards et al. (2024) highlighted participants were more critical of themselves than others.

Wilson et al. (2022) denoted challenges because social rules were confusing and, at times, this resulted in victimisation by people who assumed social norms. Participants attributed blame on themselves when struggling to "fit in" to a social situation, and ruminated on their flaws (Hartley, 2024). Hartley (2024) added that participants adopted "all or nothing" thinking about right and wrong behaviour which manifested in harsh self-judgement, with limited flexibility.

Life Stage of Diagnosis.

Qualitative data indicated late diagnosis of autism increased vulnerabilities to self-blame and internalised negative experiences across the life course (Hartley, 2024; Wilson et al., 2022). This was attributed to lack of self-understanding hindering self-kindness. Increased age was a significant predictor of lower self-compassion levels (Cai, Gibbs, Love, et al., 2023), which may be linked to stage of diagnosis, however no other study corroborated this.

Social Rejection.

Social rejection included experiences of feeling misunderstood and of being victimised. Participants described internalising criticism from neurotypical people, including victimisation across the life course (Edwards et al., 2024; Hartley, 2022; Wilson et al., 2022). Cai et al.'s (2022) qualitative inquiry also highlighted participants on the autistic spectrum felt misunderstood and, in some instances, stereotyped (Cai, Gibbs, Love, et al., 2023). Given that all four studies included participants with low self-compassion levels, this stresses the importance of early negative experiences as likely barriers to self-compassion.

Emotion Dysregulation

Four papers highlighted emotion dysregulation as a barrier to holding painful thoughts and feelings in balanced awareness. Participants struggled to recognise their feelings (Edwards et al., 2024; Hartley, 2022; Cai, Gibbs, Love, et al., 2023). Additionally,

participants struggled to separate themselves from difficult experiences, and identify the problem (Cai, Gibbs, Love, et al., 2023).

Cross-sectional data showed that emotion regulation explained a relationship between self-compassion and mental health outcomes, not self-compassion alone (Cai et al., 2023). Autistic adults with greater self-compassion levels, reported less emotion dysregulation and fewer symptoms of anxiety and depression.

Discussion

This review aimed to synthesise research findings on barriers to self-compassion development concerning autistic populations. Correlational studies suggest that Autistic traits are a predictor of reduced self-compassion. Additionally, autistic individuals with co-occurring anxiety or depression seem to experience low levels of self-compassion. Four themes were present in the data which highlight key factors underlying this relationship: backdraft, self-blame, camouflaging and emotion dysregulation.

Two papers (Cai et al., 2024; Edwards et al., 2024) reported negative physiological responses to *soles of the feet* practice. This highlighted the need for compassion interventions to consider sensory processing difficulties, which supports previous research and guidance (Baron-Cohen, 2004). Three papers (Cai et al., 2024; Edwards et al., 2024; Riebel et al., 2024) agreed backdraft was present during self-compassion exercises. This may be a barrier to self-compassion development, however increased self-compassion scores post-intervention supported literature that suggest backdraft is a natural part of the healing process (Mason et al., 2023; Galvin & Richards, 2023). Limited conclusions regarding the impact of backdraft can be drawn from only two papers, which illuminates previous concerns about a shortage of evidence concerning autistic populations (Curnow et al., 2023).

Four studies highlighted a pervasive sense of self-blame throughout the life course. This supports previous findings that autistic people experience high levels of self-criticism, which directly opposes self-kindness (Acland & Spain, 2022). Participants did not seem to view mistakes as part of human experience, moreover, rigid thinking led to harsh self-judgement. This highlights the significance of assessing and understanding individual patterns of thinking before supporting with self-critical thoughts (Baron-Cohen, 2004).

Self-blame seemed to be exacerbated by late diagnoses of autism and the associated reduced self-understanding of one's neuro-profile and individual needs (Hartley, 2024, Wilson et al., 2022). This supports previous recommendations to prioritise development of self-understanding prior to, or alongside, psychological therapies (Curnow et al., 2023). This particularly applies to compassion interventions given previous research highlights associations between self-compassion and clarity of self-beliefs or, 'knowing oneself' (Coutts et al., 2023).

Additionally, self-blame seemed to be prevalent following social situations because of interpersonal challenges and rejection (Cai, Gibbs, Love, et al., 2023; Wilson et al., 2022; Hartley, 2024). This supports the theory that lower self-compassion levels may result from ostracising experiences and internalised criticism (Galvin et al., 2023). This emphasises the importance of improving social acceptance and understanding of autistic experiences to enable self-compassion development.

Most studies (N=7) report a mean age between 30 and 45 years. The results therefore represent early to middle adulthood which, theory suggests, is pivotal regarding relationship development (Erikson, 1994). This may partly explain why results focus on barriers to self-compassion within contexts of loneliness and social rejection.

A negative correlation between self-compassion and emotional dysregulation was present in the data, however, causation could not be inferred. The direction of the relationship between self-compassion and emotion regulation remains ambiguous due to the nature of cross-sectional designs. Qualitative study findings highlighted participants feel dysregulated when struggling to recognise, label and separate themselves from painful emotions and thoughts. This supports evidence that difficulties are exacerbated by limited emotional literacy and alexithymia (Costache et al., 2024). Recognising feelings is an important first step in both intentional and automatic regulation of emotion (Gross, 2015).

Participants, however, also described challenges with mindfulness skills. Mindfulness practise is considered effective at improving emotion regulation and early evidence supports increased self-compassion following mindfulness intervention (Kounidas & Kastora, 2022; Lunsky et al., 2022). Nevertheless, a previous review indicates the need for more robust methodology to establish effectiveness with autistic communities (Cachia et al., 2016).

Camouflaging was associated qualitatively and quantitatively with lower levels of self-compassion; however causation could also not be inferred due to the cross-sectional design. Neff (2009) defines common humanity as recognizing one's experiences as part of the larger human experience; however, autistic participants seemed to perceive their difficulties as unique and isolating. Consequently, the desire to avoid social rejection because of their differences seemed to lead to some camouflaging behaviours. This supports previous evidence that perceived autism stigma predicts higher levels of camouflaging (Perry et al., 2022).

This highlights complexities when applying ideas of common humanity in the context of autism. "Common humanity involves recognizing that all humans are imperfect, fail and make mistakes…so that greater perspective is taken towards personal shortcomings and difficulties" (Neff, 2009, p.212). Autistic experiences, however, highlight a need for

experiences of social acceptance to exist alongside viewing oneself as part of an inherently flawed humanity.

Review Limitations and Implications

Variability in study design, and inconsistent reporting of barriers, increases subjectivity of the synthesis. Replicated study designs which directly investigate barriers to self-compassion would be beneficial. Over half the studies (N=5) are quantitative non-randomised with sampling biases. Participants represent those with internet access, those from autism support networks and people who self-selected to take part in research.

All qualitative studies scored 100% on the MMAT and heavily contribute to each theme during synthesis. Qualitative data facilitates in depth insights into the context and direct experience of participants. However, there was no agreement between MMAT raters when reviewing qualitative data collection and analysis (- 0.174) (Pace et al., 2012). The addition of a separate qualitative appraisal tool could have mitigated this issue.

Regarding generalisability, the review excludes professional and family experiences. For example, literature around staff experiences of compassionate applied behavioural analysis were identified and screened out. The included papers also do not capture experiences of autism and learning disabilities (30% of autistic individuals function in the cognitive range of a learning disability) and the prevalence of mental health challenges in individuals with learning disabilities is high. Therefore, further research is needed concerning barriers to self-compassion and autistic individuals with learning disabilities (Cooper et al., 2007).

The papers primarily recruited White females and therefore results are not generalisable to the full spectrum of intersectionality within the autistic community. This may bias results because females are considered to engage in more camouflaging behaviours, be

under-diagnosed as autistic, and experience lower self-compassion levels than other genders (Lai & Baron-Cohen, 2015; Neff, 2003). Identification of predominantly female samples recruited from the general population supports findings that autism is often under-diagnosed in this population (Lai & Baron-Cohen, 2015).

Regarding the search strategy and inclusion criteria, a clear definition of self-compassion resulted in exclusion of more widely considered ideas around self-compassion, such as, experiences of 'acceptance of self' (Bradley et al., 2021). Additionally, the review does not involve an autistic researcher and therefore synthesis may have misinterpreted autistic reports (Livingston et al., 2024).

Despite limitations, there are various implications for clinical practice and research. Qualitative results support a relationship between both camouflaging and emotion regulation, and self-compassion. Quantitative studies are non-randomised, therefore, more experimental research is needed which controls for confounding factors to establish cause and effect. Increased practice-based evidence utilising mixed methods design would facilitate understanding of barriers alongside effectiveness outcomes.

The fears of compassion scale was developed with a small sample of people diagnosed with depression, accessing treatment on mental health wards in the UK (Gilbert et al., 2014). Development of a fears of self-compassion scale with the autistic population may be helpful to highlight autistic experiences; given no current framework around barriers to compassion within a clearly defined autistic population exists.

Cai et al. (2018) argues that emotion regulation research concerning autistic individuals is preliminary and recommends targeting processes of emotion regulation to further understand adaptive strategies. Further investigation of the relationship between self-compassion and emotion regulation is therefore warranted.

To target self-blame, societal initiatives are pivotal to improve understanding and acceptance of autistic features, such as via education providers and employers. Results also suggest interventions need to address autistic experiences of common humanity. Given that isolation was a key theme, investigation into the effects of empathy from others in a group intervention could help. Avenues of relationship repair and connection may also be of importance.

Early intervention is warranted to reduce self-blame which develops across the life course. This could benefit from further research investigating barriers to self-compassion in childhood. Efforts to improve timely autism assessment services are also implicated. Preventative approaches for individuals scoring highly on the autistic spectrum quotient (ASQ) could include offering space to explore their sense of self and how they feel effected by their sensory and cognitive profiles. Co-produced interventions which directly target barriers to self-compassion may also help. For example, peer workers could help to identify somatic and mindfulness practices which are less likely to trigger physiological difficulties.

Conclusion

Results from nine papers with varying methods were narratively synthesised. Studies recruited adults across general populations with clinically significant autistic traits and professionally diagnosed populations. Inclusion of general populations may have influenced the high proportion of females in the review. Results indicated a relationship between both camouflaging and emotion regulation, and self-compassion levels. Experimental research investigating direction and causation of effect is required. More research is also warranted concerning safe management of self-critical memories during interventions which target self-compassion development.

Self-blame and camouflaging seemed to be exacerbated by negative social experiences, indicating a need for societal education targeting acceptance of autism. Later autism diagnosis seemed to also affect self-compassion levels, and compassion intervention could focus on self-understanding and cognitive profiling to mitigate this. Additionally, investigation into autistic experiences of "common humanity" would help target feelings of isolation and difference which negatively affect self-compassion levels. Overall, self-compassion levels in autistic populations appear low and replicable research addressing barriers is warranted.

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Paper 2: Empirical Paper

Self-Compassion Development in Adolescence: Exploring Socio-Cultural Influences Through Photo-Elicitation and an Interpretative Phenomenological Analysis.

Word Count: 8, 395

Paper 2 has been written in accordance with author guidelines for the American Journal of Qualitative Research (Appendix D).

Abstract

This study explored how older adolescents (aged 14-19) experiencing mental distress conceptualise self-compassion within their social environments. This encompassed exploration of both interpersonal and intrapersonal experiences. Self-compassion is theoretically recognised as an awareness of one's suffering alongside motivation to alleviate it. Key aspects include self-kindness during suffering, balanced awareness and tolerance of distress, and an understanding of suffering as a shared human experience.

Existing literature suggests compassion-focused interventions support adolescents with psychological distress, however, experiences of self-compassion development during adolescence remain underexplored. This is particularly relevant in older adolescence, a period which is marked by decreased self-compassion and increased distress levels.

A phenomenological approach was adopted, using Photo-Elicitation and Interpretative Phenomenological Analysis (IPA), to explore how older adolescents accessing Child and Adolescent Mental Health Services (CAMHS) make sense of the concept of self-compassion in their social contexts. Six of seven participants identified as autistic. Findings highlighted four group experiential themes: being okay with who you are; feeling understood, seeking connection; being held through the suffering, and sharing the joy; and ways of treating each other, and ourselves.

Findings are most transferable to autistic adolescents experiencing mental distress however are not generalisable, given the idiographic approach. Analysis constructed less about how participants experience self-compassion than hoped. Nevertheless, findings illuminated an adolescent focus on positive self-perception and shared positive experiences, such as playfulness. This highlighted a possible conceptual difference between adolescent and theoretical perspectives, which may need to be bridged when promoting self-compassion.

Overall, the findings illuminate a focus on relational approaches to self-compassion development, however, more research is needed to bolster the knowledgebase.

Introduction

This study sets out to explore how older adolescents accessing Child and Adolescent Mental Health Services (CAMHS) in the United Kingdom (UK) make sense of the concept of self-compassion. Older adolescence, between 14 and 19 years old, is a key stage of social and emotional development (Badura et al., 2024), and self-compassion as a protective factor from mental distress during this period is an expanding area of interest (Carona et al., 2017; Amari and Mahoney, 2022). UK data indicates a rise in referrals to CAMHS between 2017 and 2023, from 5% of England's child population to 8%; disproportionate to population growth (NHS England, 2024; Children's Commissioner, 2024).

Global data indicates that anxiety and depression increase in older adolescence, underscoring the importance of providing emotional support throughout childhood (Newlove-Delgado et al., 2023). There are several theories which indicate why adolescents may be vulnerable to mental distress. It is developmentally typical for adolescents to focus on establishing a sense of congruence in identity and this can lead to anxiety or self-criticism, particularly as there is often heightened comparison to peers (Erikson, 1968). They also experience biological changes involving increased emotional intensity and awareness of their sexuality (Hegde et al., 2022), leaving them vulnerable to internalising body image standards and feeling conflicted amongst social norms.

Adolescents are typically exploring their own values and when incompatible with societal expectations of moral behaviour, this can trigger guilt and shame (Kohlberg, 1958). Furthermore, cognitive abilities increase (Piaget, 1972). Abstract thinking develops, sometimes leading to increased questioning and confusion, hypothetical thinking expands and can trigger increased worries or perceived judgement from others and metacognition develops, enabling reflection and exacerbating risk of rumination.

In considering adolescent mental distress, self-compassion seems to be an associated factor. A negative correlation between adolescent self-compassion and psychological distress is supported via meta-analysis, with a large effect size (Marsh et al., 2018). Furthermore, this relationship is more pronounced for older adolescents, who report lower self-compassion levels (Bluth & Blanton, 2015). However, there is a lack of research explaining why older adolescents are reporting low self-compassion. Moderating factors may be present, for example, self-esteem more strongly mediated distress compared to self-compassion in recent studies (Graham, 2018; Athanasakou et al., 2020). To introduce the study further, the concept of self-compassion is expanded upon, and the evidence base regarding self-compassion as a protective factor in adolescent mental health explored.

Conceptualising Self-Compassion

Compassion was originally defined as, "to suffer with" (Oxford University Press, 1992, P. 123), and evolved to include a motivation to alleviate suffering (Gilbert, 2017; Dalai Lama, 1995). A systematic review identified five key components of compassion: recognition of suffering, awareness of the universality of human suffering, acceptance of the associated feelings, and motivation to alleviate suffering (Strauss et al., 2016).

Self-compassion is understood as compassion turned inward and defined using three binary constructs: self-kindness or self-judgement, viewing self in isolation or part of common humanity, and over-identification with experiences versus non-judgemental awareness (Neff, 2016). Common humanity refers to the perspective that all humans are connected as flawed people who suffer (Neff & Vonk, 2009). Self-esteem relies on external validation, whilst self-compassion is devoid of rigid self-evaluation (Neff, 2003).

Compassion is also a dynamic process which is embodied in various ways across different communities and relationships, for example, children may offer gestures such as a

comforting touch whilst adults may show compassion when mourning together through song (Denborough, 2005).

Development of Self-Compassion

Evolutionary perspectives suggest that compassion evolved as a survival method to strengthen social bonds and promote collaboration for survival (Gilbert, 2017; Narvaez, 2017). In this regard, emotions are driven by three physiological systems: the parasympathetic nervous system fosters soothing to promote rest, the threat system protects from danger, and the drive system motivates a pursuit of goals (Gilbert, 2014). An overactive threat or drive response and an underdeveloped calming system can lead to psychological difficulties.

Psychological research underscores the role of relationships when fostering self-compassion and encouraging the parasympathetic nervous system (Gilbert & Irons, 2009). Attachment theory highlights that individuals develop self-protective strategies in response to the behaviours of others, which influences the ways they seek, receive and offer care (Crittenden, 2006; Gilbert, 2017). Early exposure to social threats, such as rejection, increases the risk of shame and blocks experiences of compassion (Gilbert et al., 2003). Furthermore, adolescents are driven by the social need for belonging and are therefore vulnerable to shame exacerbated by intense peer comparison (Erikson, 1968).

Gilbert (2014) argues that affiliative emotions such as gratitude and empathy help Humans to bond and feel relationally safe. Additionally, developing a capacity to receive care and to care for others may be necessary before developing compassion for oneself (Breines & Chen, 2013; Brill & Nahmani, 2017).

Applications of Compassion

Compassion interventions aim to foster feelings of safety and social connection through co-regulation in relationships and sensory-based regulation (utilising meditation,

self-soothing exercises, compassionate imagery, and breathwork) (Gilbert, 2017). Compassion Focused Therapy (CFT) is a *third wave* therapy which targets compassion as an adaptive way of relating to distressing cognitions and emotions. Effectiveness of third-wave therapies, which incorporate compassion, in alleviating adolescent distress is evidenced across several Randomised Controlled Trials (RCTs) (Perkins et al, 2023). A recent review of the role of compassion concerning adolescents experiencing interpersonal traumas denotes that Compassionate Mind Training alongside trauma-focused Cognitive Behavioural Therapy reduced self-criticism, and improved emotion regulation (Amari & Mahoney, 2022).

Compassion is also incorporated into some mental health service cultures. Staff perspectives of compassionate care on CAMHS in patient wards illuminate a need for psychologically safe spaces to help young people feel listened to, and for the whole service culture to be compassionate to enhance staff wellbeing and capacity to care for others (Maddox & Barreto, 2022). School initiatives focus on preventative, collective approaches to fostering mental wellbeing through compassion, rather than individualised self-compassion development when severe distress manifests (Welford & Langmead, 2015; Public Health England, 2021).

Adolescent Experiences of Self Compassion

Adolescents may be vulnerable to low self-compassion levels if they have not developed ways of soothing during intense emotional distress, resulting in limited internal resources to cope with feelings of shame or failure which are often exacerbated during this developmental stage (Gilbert, 2014; Neuenschwander & Gunten, 2025). Barriers to accessing compassion may be present due to aversive memories whereby compassion was perceived as a threat, or a shameful or unhelpful response (Gilbert, 2014).

Additionally, acting with self-compassion relies on complex cognitive and emotional skills including shifting attentional focus, social awareness, empathy, perspective-taking,

tolerating and regulating difficult emotions, and having a motivation to reduce distress (Neuenschwander & Gunten, 2025).

There is only a small number of studies exploring experiences of self-compassion development in adolescence and why levels of self-compassion may be low. Berardini et al. (2021) offer insights from participants aged 12-18 years who provide caregiving to family members. They highlight several considerations: participants prioritised caring for others which increased positive self-regard, self-care felt important but there was no time for it, and feelings of guilt and self-criticism were associated with, and therefore blocked, self-compassion. Dunkley-Smith et al. (2021) depict how 18–25-year-olds with parents experiencing mental illness wanted permission from others to enact self-compassion, highlighting the significance of support from people with similar experiences.

An Interpretative Phenomenological Analysis (IPA) conducted with Canadian adolescents, aged 15-17 years, who engaged in talking therapy within the year before interviews depicted that a sense of common humanity (feeling connected to others as suffering exists for all) was not a key experience (Klingle & Van Vliet, 2019). Instead, participants emphasised making oneself likeable to others and having to prioritise their needs over the social self. They also described balancing self-improvement with self-acceptance and seeking short-term avoidance of distress.

Aims and Rationale

There is expanding interest in self-compassion as a protective factor in adolescent mental wellbeing, however, less is known about experiences of how and why adolescents experiencing distress may struggle to develop self-compassion. Given the negative association between self-compassion and psychological distress, this study intends to add to

the paucity of evidence concerning how adolescents experience self-compassion during distress.

Additionally, this study aims to explore how adolescents make sense of self-compassion within their social environments. This is important because research suggests self-compassion develops both inter- and intra- personally and is shaped through social experiences. Furthermore, adolescents are particularly conflicted with social expectations when making sense of self-compassion (Klingle & Van Vliet, 2019).

The study hopes to inform systemic thinking around the development of self-compassion by exploring adolescent interpretations of socio-cultural influences on self-compassion. In doing so, the researcher asks the question: how do older adolescents experiencing mental distress make sense of the concept of self-compassion within their social environments?

Method

The study took place within CAMHS in South Staffordshire, UK. CAMHS consists of multi-disciplinary teams supporting the social, psychological and emotional development of children aged 0-18 years (NHS England, 2024). Keyworkers develop person-centred care plans concerning severe mental health difficulties, and work alongside education systems and local authorities. Care plans may include psychiatry, nursing, occupational therapy, speech and language therapy, and psychological therapists who offer evidence-based therapies (National Institute for Health and Care Excellence, 2019).

Ethical Considerations

Ethical approval was attained from the University of Staffordshire Ethics Committee Board and the National Health Service Research Ethics Committee and Health Research Authority (Appendix E). Participants were given mental health support signposting sheets (Appendix F), and information about staying safe online (Appendix G).

Design

A qualitative approach explored the complexities of experiencing self-compassion, from the older adolescent perspective. With an epistemological commitment to exploring how participant's construct meanings of self-compassion through lived experiences, the youth advisory group for Birmingham's CAMHS were consulted on whether they could describe their experiences of self-compassion without a predetermined definition. They shared how their sense of self-compassion was unique to their individual experiences. This influenced recruitment criteria: knowledge of a definition of self-compassion or participation in a compassion intervention was not a prerequisite to take part. This supported an investigation of participant's own meaning-making around self-compassion from lived experiences in their social contexts.

Interpretative Phenomenological Analysis (IPA) was adopted to focus on individual lived experiences (Smith et al., 2021). IPA was helpful for focusing on participant's own language. Furthermore, IPA enabled exploration of ways of relating to self-compassion; aiming to move investigations beyond self-compassion as a trait and instead, explore dynamic and personalised experiences. Additionally, IPA does not isolate phenomenology from context. It acknowledges that interpretation of experience develops through social, relational and cultural interactions. This supported exploration of sense-making as constructed within social context.

Photo-elicitation was incorporated as a collaborative approach to enhance depth of interview dialogue (Harper, 2002). The use of images was employed to elicit interpretations and offer visual representations when describing an abstract concept, moving away from predefined ideas and towards individual experience (Reid et al., 2018; Burton et al., 2017). Furthermore, it was hoped the imagery would invite emotional expression, particularly if participants did not yet have language for their experiences. This aligned with techniques from compassion interventions which use imagery to foster compassionate experiences (Carona et al., 2017). The imagery was not analysed, and analytic focus stayed with the depth of interview dialogue.

Semi-structured interviews were utilised in alignment with an IPA approach (Smith et al., 2021). A semi-structured topic guide helped to focus on participant-led interpretations, with flexibility for the researcher to probe for further meaning. IPA is concerned with how participants make sense of their lived experiences, therefore questions invited participants to reflect on how they relate to the concept of self-compassion, and what their chosen images evoked.

Altogether, this design acknowledged the complexity of self-compassion as an abstract, dynamic experience and created opportunity for participants to approach it ideographically, via imagery, without an imposed definition. The use of imagery hoped to elicit individual interpretation and scaffold conversation about the more vulnerable aspects of self-compassion experiences. Overall, data collection aimed for a richness in interview dialogue to explore personal accounts of self-compassion.

Recruitment

The study aimed to recruit between six and ten participants, as IPA explores detailed accounts of individual experiences and suits smaller sample sizes (Smith et al., 2021). CAMHS keyworkers were invited to share the study information and establish consent for the researcher to contact the adolescent or their caregiver (Appendix K-N). Those aged 14-15 years required caregiver consent. A recruitment video was shared alongside information sheets. Eight participants were identified and seven people consented to take part after being fully informed of the study requirements.

Inclusion criteria were met if the participant was aged 14-19, accessing support from a CAMHS keyworker at the time of the study, and could read and write in English. Any individuals concerned about taking part in the study due to risk to self or others were not eligible.

Procedure

Data was collected using semi-structured interviews following a photo-elicitation task. Participants were invited to take photos of “what self-compassion means to you” based on experiences over a two-week period (Appendix H). Alternatively, participants could create artwork.

All participants chose to complete their interview in person at CAMHS where they described what their chosen images represented to them and were guided to share details of personal meaning-making. The semi-structured interview guide was used (see appendix I). Participants were also invited to complete a voluntary demographics information sheet (Appendix J). Interviews lasted on average 60 minutes.

Participants

Seven participants consented to take part in the study (table one), including five females and two males. All names are anonymised. The mean age of participants was 16 years and most identified as autistic (N=6). Participants were invited to complete the photo-elicitation task either independently or with family, friends or keyworkers. The researcher clarified whether participants spoke about self-compassion with a trusted person, or researched the concept ahead of interview, and whether participants completed the photo task as planned (table two).

Table 1

Participant Characteristics

Participant	Age	Gender	Ethnicity	Neurodiversity
Tommy	16	Male	White British	Autism Diagnosis
Noah	16	Male	Unanswered	-
Amy	17	Female	White British	Waitlist for Autism assessment
Amber	14	Female	White British	Waitlist for Autism assessment

Sienna	15	Female	White British and Hispanic	Autism Diagnosis
Elena	16	Female	White British	Autism Diagnosis
Betty	15	Female	White British	Autism Diagnosis

Table 2

Approach to the Photo-Elicitation

Participant	Approach to the photo-elicitation task	
	Approach to the photo-elicitation task	Resources used to make sense of self-compassion pre-interview
Tommy	Forgot to do the photo-elicitation task, used photos already on his phone for the interview.	Mother, CAMHS keyworker
Noah	Completed photo-elicitation as planned (photos).	Completed independently
Amy	Completed photo-elicitation task as planned (photos).	Google, friend
Amber	Created Pinterest board of pre-existing, publicly accessible photos and quotes.	Family, Google, social media
Sienna	Completed photo-elicitation task (photos) and also referred to photos	Completed independently

	from before the study which were available on her mobile.	
Elena	Completed photo-elicitation task as planned (photos).	Google
Betty	Completed photo-elicitation task as planned (created paintings).	Nobody, completed independently

Analysis

The analysis followed iterative steps for IPA (Smith et al., 2021). Each interview was transcribed by the researcher, and analysis began following the first interview. The researcher read each transcript several times and initial notes focused on descriptive, linguistic and contextual points. Personal experiential statements were formed (Appendix O). At this stage, six participants met with the researcher to member check the statements. No misinterpretations were reported however five participants expanded their thoughts (see appendix P).

Statements were printed onto paper, and the researcher mapped connections and further interpreted the statements. This led to the development of Personal Experiential Themes (PETs) for each transcript (Appendix Q). Connections on a group level (across all transcripts) were explored, attending to convergence and divergence between each participant's PETs, and Group Experiential Themes (GETs) and subthemes were developed (Appendix R). A master-table documented quotes against each GET to assess whether quotes corresponded well to themes (Appendix S). Analysis and writing of the results were intertwined, as expected in IPA, writing was an integral aspect of the analytic process (Smith et al., 2021).

Reflexivity

The researcher reflected through journalling and supervision (Larkin et al., 2006). Self-compassion did not seem commonly defined or spoken about within participant social environments. It seemed more a psychological term, rather than a word utilised by participants.

The researcher considered how participants described self-compassion in comparison to the theoretical definition: a recognition of, and motivation to alleviate, one's suffering (Gilbert, 2017). They noted when participants described an awareness of their suffering and motivation to alleviate it, and how they were diverging from this experience. The emphasis on coping with "suffering" is the researcher's language. Nevertheless, all data constructing what was important to the participants about self-compassion was incorporated in the interpretation. For example, many participants spoke about shared positive experiences of laughter and playfulness, as well as experiencing painful emotional experiences.

The researcher also noted their understanding of self-compassion as a way of fostering wellbeing through a non-judgemental attitude towards oneself, even in the event of mistakes, which contrasted participant descriptions. Participants seemed to describe experiences closer to self-esteem development that evaluates self-worth based on one's performance and comparison to external factors (Neff & Vonk, 2009). The analysis did not exclude experiences which the researcher related more to self esteem, moreover, stayed with participant meaning making. This enabled exploration of how participant's experienced non-judgemental self-relating and unconditional acceptance of the self, if at all.

Additionally, psychological theory suggests having a sense of relational safety activates the parasympathetic nervous system which regulates pro-social behaviour and compassionate relating to difficult emotions (Porges, 2022). Non-judgemental experiences,

therefore, were considered a necessary condition to be able to relate to oneself without judgement. This influenced analysis because non-judgemental spaces, when brought to interviews by participants, were interpreted as a contextual factor influencing access to self-compassion.

Epistemology and Ontology

A relativist ontology and a social constructivist epistemology were adopted. A relativist ontology assumes that adolescents' realities of self-compassion are shaped by their social and cultural interactions. Analysis explored how adolescents make sense of socio-cultural experiences of self-compassion, and what matters to them about self-compassion in the context of mental distress.

A social constructivist position was also adopted whereby multiple lived realities of self-compassion are possible. This approach acknowledges that experiences are embedded within relationships, language, and culture. The analysis aimed to interpret the participant's position on conceptualising self-compassion, which is co-constructed within their social worlds (Smith et al., 2021).

Results

This study explored how older adolescents make sense of self-compassion during mental distress, resulting in four Group Experiential Themes (GETs) and five subthemes (table three). Each theme was relevant to at least four participants. Participants' photos/artwork anchored conversations in their lived experiences.

Table 3

GETS Overview

Group experiential themes and subthemes	Participant representation
Being okay with who you are	Amber, Amy, Betty, Elena, Noah, Sienna, Tommy
- The conditions for growing self-love	Amber, Betty, Elena, Sienna, Noah, Tommy
- Non-judgemental spaces	Amber, Amy, Betty, Elena, Noah
- Saying no to the way things are normally done	Amber, Betty, Elena, Tommy
Feeling understood, seeking connection	Amber, Amy, Betty, Elena, Sienna, Noah, Tommy
Being held through the suffering, and sharing the joys	Amber, Amy, Betty, Elena, Noah, Sienna,
- Being held through the suffering	Amber, Amy, Betty, Noah, Sienna
- Shared laughter and playfulness	Amy, Elena, Noah, Sienna
Ways of treating each other, and ourselves	Amber, Betty, Sienna, Noah, Tommy

Being Okay with Who You Are

The first GET depicts the participants' struggles with accepting themselves. The subtheme, the conditions for growing self-love, portrays participants' descriptions of self-compassion as being liked or loving themselves. Participants described the outside influences on their view about themselves. They largely described their development of self-love as conditional on positive judgements, however, the second subtheme depicts non-judgemental spaces in which participants experienced self-acceptance. The final subtheme, saying no to the way things are normally done describes how participants resisted social norms as a way of self-acceptance.

The Conditions for Growing Self-Love

Participants seemed focused on viewing themselves positively and suggested a need to love oneself to experience self-compassion. They described how both the positive and negative words of others affect their self-perception. For example, several participants referred to bullying from peers when describing how "self-compassion can go two ways. It can be more like loving yourself and also be very negative, you can think very negative…You can think you're worthless and stuff" (Betty). Betty gave an example of the way peers spoke about her appearance, sharing "when I was at school it was quite negative" and how this impacted her self-compassion "like the thoughts are raining down onto it" (Figure 1).

Figure 1

"The Thoughts Raining Down Onto" Self-Compassion

Similarly, participants described experiences of being liked as their sense of self-compassion, for example, Elena suggested self-compassion was experienced in compliments from others and described a pursuit of them, “I think whenever I wear clothes or like nice fashion stuff, that's when I get like my most compliments.” Tommy shared “I'm weird. No-one likes me. What can I be positive about?” In the context of being bullied, Tommy’s question alluded to an impossibility of liking oneself amongst cruel judgements from peers.

Noah shared “that you can only find it (self-compassion) in yourself, if you love yourself, which is very hard to do if you hate yourself more than you love yourself.” His emphasis on “only” finding self-compassion by loving yourself contradicted other participant narratives which emphasised outside influences, nevertheless, Noah highlighted a difficulty in achieving self-love from within. Several participants referred to self-love however, only Tommy questioned “…does anyone actually feel like that?” This suggested a sense of disconnect in comparison to how others claimed to feel. Overall, participants seemed focused on self-compassion as a positive view of oneself.

Non-Judgemental Spaces

Participants emphasised the importance of non-judgemental spaces to accept themselves. Participants described experiences of being accepted by CAMHS, as exemplified by Noah, “they (CAMHS) just let me talk about what I wanted to talk about. They didn’t judge. They didn’t say I was selfish. They just listened”.

They also spoke about contrasting experiences such as when Betty shared that she felt judged by her teacher, “he would say you should know this. But I have learning difficulties...” She emphasised her teacher stating “you should know this” which was interpreted as a sense of judgement and lack of acceptance. Amber alluded to the risk of social judgement from peers in school and contrasted this with CAMHS groups, which offered a sense of safety:

> Normally I'll never see you again (at CAMHS group). These people (at school) I have to see. These people at school, I'd have to see every day for five years. If I tell you here yeah… and everything just comes back at you in your school. Anything can hit you back in the face.

Amber exemplified how her family did not judge her when she was struggling, “I mean, my family is very good in understanding. We have very close relationships within my whole family. I think it's good to just know nobody is going to judge you, which helps with the self-compassion.” Several participants also emphasised non-judgemental spaces in the context of their relationships with their pets, as exemplified by Noah, “she [pet dog] can't talk, so she can't judge…” Overall, participants seemed to cherish non-judgemental spaces where they could be themselves.

Saying No to the Way Things Are Normally Done

Several participants shared a sense of resistance to social norms, interpreted as a step towards self-acceptance in resisting others' judgements. Betty and Elena expressed resistance to social norms through clothing and style choices. They seemed to develop a sense of self-acceptance by reclaiming independence over their likes and dislikes, as exemplified by Betty, "it can be quite negative if friends and family say something, but I try not to listen to that because they, they aren't me. It's my body, I can wear what I want." This suggested an assertion of autonomy and was interpreted as a move towards self-acceptance. Similarly for Elena, rather than fearing critique from others, uniqueness seemed to function as a source of self-acceptance:

> There's a difference. Because I used to think, people are looking at me and thinking that looks so stupid in school. But that's because I'm wearing what everyone else wears. And I think that's just something different. But now that I'm standing out in a different piece of clothing, I feel comfortable in it...

Several participants suggested it was difficult to reject other people's opinions. Amber highlighted, "if somebody was to say something bad about it, I wouldn't do it. It would be like, well, they've said it's wrong, so I'm not going to do that." A sense of powerlessness was often constructed for example Elena shared, "erm (sigh) I don't like it. I really don't like it. But I mean, there's nothing you can do because they're like, they're higher than you, basically. And because they're all adults, you can't, you can't say anything."

Amber and Elena both described a rejection of the expectation to achieve in school. Amber decided to "put herself first…" by leaving a school environment that did not support her, and although previously sharing how difficult it is, Elena described standing up for herself against teachers:

> …they said, (Elena), that is not good enough. You, you will not. I'm not going to accept the fact that you don't care. Everyone has feelings towards their exams. You obviously have an emotion towards them. I really don't. I feel nothing if I think about them. I don't feel anything about them. I'm just happy to leave this place.

When describing self-compassion Tommy resisted social messages to, "wake up and do your routine and do great and control your mind". His iterations of "come on" when describing a pressure around, "putting 100 things on their face and having a run, come on?" alluded to his sense of frustration. However, in contrast to some participants who found more self-acceptance through resisting norms, Tommy shared "I'm no good at it" which suggested he felt he should be able to meet the expectations.

Altogether, participants illustrated the potential for resistance against social expectations to act as a bridge towards self-acceptance, yet several highlighted how not meeting social norms can result in negative judgements.

Feeling Understood, Seeking Connection

When explaining what self-compassion meant to them, all participants seemed to focus on moments when other people understood, or misunderstood, their experiences. Furthermore, feeling understood seemed to influence a sense of connection with others.

Tommy shared how other people tended to encourage positivity around him, but he preferred if others showed understanding of negative experiences instead of minimising them, "yeah well it's kinder than just being delusional and saying that everything's great when it's not." His depiction of positivity as "delusional" seemed to emphasise disconnection between his reality and the responses of those around him.

Elena described that the head of pastoral care did not understand her panic during the school day, "I physically cannot breathe. And she said I'm being over dramatic. I should just

go…" Elena depicted a vast disconnect between her felt experience and the instruction from pastoral care in response.

Amy, Elena and Tommy seemed particularly focused on the sincerity of the understanding being offered. Elena, for example, described the community initiatives of her favourite music band and how "it's not like they're oblivious, they actually help their fans, and it's not like, oh, you're going through this tough time, here you go…They actually understand." Her use of the word "actually" was interpreted to emphasise a feeling of sincere understanding in contrast to other experiences.

Amy and Tommy alluded to a felt sense that school didn't convey a true understanding of their experiences. They both described "lies" told by school during mental health assemblies which suggested a sense of insincerity, exemplified by Amy, "obviously it was complete lies but you'd be like yeah okay whatever, just get through this 15 minutes."

Several participants referred to connecting with stories of other people who had similar experiences. Amy described finding comfort in fictional narratives that validated her feelings, "but it's almost it's seeing, like, characters, they almost feel like similar feelings. It's sort of a bit nice because I'm like, well, I'm not the only one who feels like this." Amber explained how TikTok enabled her to witness others' experiences that seemed identical to her own, affirming that she is not alone, "there's a girl on there who literally, it's like she's me in another person. It's crazy. She's had practically the same experiences that I've had… I never thought that there were people like me out there."

Noah also valued hearing about difficult experiences which were similar to his own, "they (CAMHS) made it relatable… just getting some really bad examples of life..." and Elena emphasised how her favourite band acknowledged saddening experiences, "they met a (band community member) who had cancer, and she wouldn't live for very long. When she

died, they made like a whole ceremony". In this regard, Elena seemed to value a space where suffering was recognised.

Furthermore, participants alluded to a sense that suffering was not commonly shared in their social circles, as exemplified by Amy, "no, I don't, I don't really know, I don't see young people upset, right. People don't like it. And if they do, they're not, like around, like, they're, like, off somewhere, like they're just sitting in the toilet or something." This suggested that although participants valued feeling understood, it was difficult to share negative experiences with peers.

Overall, participants seemed to be communicating that they do not want to feel alone in their experiences. Elena, Amy and Tommy seemed to value sincere expressions of understanding. Several participants emphasised connecting with others through shared experiences of suffering.

Being Held Through the Suffering, and Sharing the Joys

Participants depicted a significance in someone being alongside them and this applied across binary experiences of the suffering and the joy. The first subtheme portrays participants experiences where they felt held by the presence of others during distress. The second subtheme refers to participants perceptions of self-compassion as existing in moments of shared joy.

Being Held Through the Suffering

Five participants spoke about valuing others being alongside them in their suffering. Participants shared photos of their pets and described the way in which they sit with them during distress, such as Betty when she felt "really panicky, he sits on my lap and just hugs me until I calm down" or Noah who shared, "like, the other day I lost the plot, broke down, self-harmed, and my dog wouldn't leave my side until I was all right, she was just next to

me.” The way participants framed their pets’ reactions as responding to their emotional states by moving towards them, was interpreted to mean participants felt their pets joined them in their suffering.

Amber emphasised moments when others recognised she was suffering and responded with affection, “I think my mum can…She always gives me a cuddle. She always knows when something is wrong”. Not all participants emphasised affection. Sienna instead highlighted that her CAMHS keyworker “lets you take your time. Some people just want you to get it out and just talk to them, but (keyworker) will let you take your time.” This was interpreted to mean her keyworker did not pursue conversation but was still supporting Sienna.

A similar sense of quiet space was depicted by Noah, however he described nature as holding suffering “…most people just go there (to a lake) to walk and cry, some people just go there to clear their mind. It's like many different things. Yeah, it's got, what you can do for you. I've done both.” Noah highlighted that “it's calm and soothing nature is, it’s just one of them things that's like there when you're alive and it'll be there when you're gone innit.” This was interpreted to emphasise nature as a consistent presence which holds the space one suffers within. Overall, participants seemed to cherish spaces in which their suffering was supported.

Shared Laughter and Playfulness

Participants also emphasised self-compassion as a joyous experience found in shared laughter and playfulness. When asked about self-compassion experiences, Elena exemplified, “me and my other cousin, we were laughing our heads off…she just lay there just brawled out on the trampoline!” It was interpreted that compassion felt as much about being alongside in enjoyment, as about acknowledging difficult experiences.

Noah also emphasised shared playfulness however he focused on a sense of innocence, “just put a smile on my face, watching her (pet dog) play, the innocence of it all.” This was interpreted, within the context of Noah’s interview, as an escape because he shared a sense of the world as dangerous and unpredictable. Sienna’s emphasis on laughing together and spending time together suggested a joy in being with loved ones, “we just laugh or just watch a movie or something. It's just fun. It's just nice to spend time with him [father].”

Distinctively, Amy seemed to use playful humour as her way of sharing suffering, “I think it's just a natural thing for me, any like serious thing, anything like serious that's happened, I make a joke out of which I really shouldn't, but we are, it helps us. Maybe that's one way of self-compassion…” The use of plural pronouns, “we” and “us” was interpreted as speaking to the inclusivity of a collective experience.

Altogether, these participants highlighted experiences of self-compassion found through sharing experiences of playfulness and laughter. Noah and Amy specifically alluded to finding respite from negativity in these experiences.

Ways of Treating Ourselves and Each Other

Five participants emphasised caring for themselves, how they treat others and the ways in which others treat them. This encompassed caring for their own physical and mental health as exemplified by Betty, “keep healthy, keep your mind healthy, just that. And be kind to yourself and treat yourself as a person…” and Tommy, “like people run to be healthy and I'm like, that's fair enough, but I can’t be a****.”

Several participants mentioned that their health can deteriorate if they do not take care of themselves, for example, in the context of family illness Sienna emphasised, “hmm, don't, like, take things for granted. Don't take the happiness for granted. You have to make sure you're always looking after yourself.”

They highlighted difficulties with self-care when struggling with their mental health, as exemplified by Tommy who seemed to feel that low motivation was stopping him from exercising, “but I'd probably be happier, but I can't be a**** to do anything” and Amber who shared:

> I mean a few months ago when I burnt out it went. I lost everything. I wouldn't do anything. I was just so tired and ever since then it's slowly been getting a bit better. Like it's not as tiring to wash my hair or to do anything…

Participants alluded to needing momentum to engage in self-care activities, for example, Amber highlighted that her passion, and the influence of her mother, motivated her to care for her nails “and I've just got a passion for it. And my mom used to do nails as well. So, she’d do them for us. And then I learned how to do them myself. And I love doing them.”

The participants emphasised the way other people treated them and seemed to focus on acts of kindness and care. For example, Noah described, “my mom? Yeah. She takes care of the dog, me, my sister. She's always there for us. Same thing goes for my sister” whilst Sienna shared, “if I'm like over stimulated, he'll (boyfriend) brush my hair” and she referred to her granddad’s altruism as he would “bring us out to the park every day. Just take us to the shop. Like, even if he didn't feel very well, if I wanted to go to the park, we'd go to the park…” Betty also exemplifies a sense of appreciation for altruistic acts:

> Once I was waiting for Mom outside there, and it was storming and raining and the Priest, Chaplain, I still don’t know which one, and he got me in, told me to come in and he got me a drink and stood me by the candles to warm up my body.

Several participants alluded to whether their acts of kindness to others were returned, as exemplified by Elena, “because in my way, you want to be treated how you treat others... because I don't see the point. If I'm nice to someone and they're just rude back, there's, there's

no point.” Betty shared a sense of hope that the compassion she offers to others will be returned “…it spreads the love. It might not seem like it sometimes, but it does work, and I do get repaid” (figure 2).

Figure 2

Compassion Radiating From Within

Notedly, Betty and Elena both emphasised compliments when describing compassionate acts, for example, Betty described “even if it's just a nice compliment. It can be nice. It can save someone. Someone could be so depressed, and you could be so nice to them and could save their life. It's just the little things that help.” This seemed to link to building a likeable sense of self, as described in the subtheme, conditions for growing self-love.

Noah shared his regrets about some of his past actions, and indicated he was struggling with forgiving himself, “as long as I can help someone else and redeem myself in that way, it feels like I’m doing something worthwhile, even though it feels like I’m never going to be redeemed for it.” In this regard, Noah went on to share “my self-compassion is to

help other people.” In contrast, Sienna described how her granddad taught her to always treat yourself as you treat others, “whatever he was giving out, he would also give it to himself. So, he always made sure that as much as he's looking after his family, he will also make sure that he’s okay too.”

Overall, participants seemed to highlight a responsibility to treat themselves with care, whilst emphasising the challenges involved in maintaining their physical and mental health. They highlighted how the way they treat themselves is intertwined with relationship experiences.

Discussion

This study explored how seven, 14–17-year-olds accessing mental health services made sense of the concept of self-compassion within their social environments. The discussion relates key findings to current literature and considers wider implications. Notedly, six of seven participants identified as autistic, therefore findings are most valid when applied to experiences of autistic individuals accessing CAMHS (Yardley, 2008).

Data collection and analysis were less illuminating of sense-making processes than hoped, including both the intrapersonal and interpersonal. This reflects a limitation concerning the methodology in answering the research question, as the focus shifted away from sense-making towards participant understanding and descriptive experiences.

Participants understanding of self compassion seemed more aligned with theories of self-esteem development. Self-compassion is theoretically understood to develop through flexibility of thought about oneself, including unconditional acceptance of flaws, whereas participants often focused on experiences of developing a positive self-perception (Neff, 2003; Dalai Lama, 1995). Compassion is also considered a motivation to alleviate one's suffering and offer a caring response, even whilst feeling flawed (Gilbert, 2017).

Several participants depicted that it is too challenging to be kind to oneself when feeling self-critical and being bullied negatively impacted their self-perception. This aligned with research suggesting exposure to social threats influences higher levels of self-criticism (Gilbert et al., 2003), and adolescents tended to focus on being liked when talking about self-compassion (Klingle & Van Vliet, 2019). Autistic individuals prefer a rigid style of thinking which offers a sense of predictability (Baron-Cohen, 2004). This may have exacerbated dichotomous thinking about positive self-perception in opposition of feeling disliked.

Participants also referred to resisting the way things are normally done such as, educational expectations or clothing norms, when developing a positive sense of self. This supports previous research whereby participants were balancing their own needs with social expectations (Klingle & Van Vliet, 2019). Additionally, this supports developmental theory highlighting conflicts between personal values and moral expectations when exploring identity (Kohlberg, 1958).

Overall, it is understandable that participants prioritised positive perceptions of themselves when making sense of self-compassion, because it fits the Human need to feel valued by, and safe with, others (Gilbert & Irons, 2009). The findings support developmental theories concerning an adolescent focus on fitting into social groups and finding a congruent sense of self (Erikson, 1968). Overall, this finding indicates a developmental focus on self-worth and identity construction, rather than emotional flexibility or space for acceptance of imperfection. Bridging this conceptual gap could be key for fostering self-compassion at this developmental age.

Additionally, the findings support theory which suggests awareness of suffering as a common experience reduces isolation and increases self-kindness (Neff, 2016). Participants highlighted the significance of feeling understood by others with similar experiences, however, this contrasted previous research with non-autistic adolescents who did not depict shared experiences as an experience of self-compassion (Klingle & Van Vliet, 2019). The sample may have influenced this finding because autistic populations experience reduced self-compassion due to feeling misunderstood by others (Livingston et al., 2024; Hartley, 2022).

Furthermore, this study adds an adolescent-emphasis on shared experiences of positivity as a pathway to self-compassion, rather than reducing self-compassion development into ways of relating to suffering. Playfulness was emphasised, aligning with positive psychology's understanding of emotions arising through positive resonance, whereby self-compassion is considered an embodied moment existing between people (Fredrickson & Siegel, 2017). Gilbert's explanation that affiliative emotions such as understanding, warmth and connection, activate the parasympathetic nervous system may link to the participants' emphases on playfulness (Gilbert, 2014).

Adolescents in previous research also emphasised short-term avoidance of overwhelming negative emotion (Klingle & Van Vliet, 2019). Participants in this study, however, described tolerating suffering when they felt held by someone, or a presence, alongside them. Notedly, most participants spoke of animals or nature being alongside them in their suffering which may relate to their sense of vulnerability to judgement when sharing suffering with another person.

Findings aligned with Gilbert's understanding of compassion developing through care (Gilbert & Irons, 2009). Participants described self care practices, previously highlighted as an aspect of self-compassion by young carers (Berardini et al., 2021). The findings depicted self-care as a way of treating themselves which nurtured their mental and physical health. This contrasted previous findings which suggested caring for one's physical self was driven by a desire for others to perceive them positively (Klingle & Van Vliet, 2019). The focus on health may have been influenced by recruitment taking place within CAMHS.

A need for support systems to encourage and model self care was constructed. Noah conveyed a sense of helping others to feel better about himself which corroborates findings that caring for others can boost positive self regard (Berardini et al., 2021). Most participants

shared a sense of wanting to be treated as they would treat others and some described that self-compassion exists in experiences of feeling cared for. In this regard, participants may be supporting research which highlights receiving compassionate care leads to extending care towards oneself (Brill & Nahmani, 2017).

Limitations

IPA is well placed to explore interpretations of nuanced concepts; however, findings are idiographic and not generalisable to the wider population. Self-compassion is an abstract concept and there was no shared definition, therefore the study investigated participant's understandings of self-compassion alongside their sense-making of experiences. This methodological choice reduced the depth of data collection and analysis. Furthermore, due to differences in recognising and articulating emotions and cognitions, autistic participants may have needed more support in interviews than was offered to be able to access sense-making processes (Baron-Cohen, 2004).

There was also variability in the photo-elicitation task. Tommy did not complete the task in the suggested two-week period, instead using photos available on his phone in the interview. Amber created a Pinterest board instead of taking photos, and Sienna shared photos from before the research study, highlighting how exploring self-compassion triggers memories. This limited interpretation of current social, interpersonal influences. Future research could narrow the context of the study to focus on socio-cultural experiences in one setting such as, education, CAMHS, social media, family, or friendships.

Most participants identified as White British, which limits the theoretical transferability across ethnically diverse populations. IPA prioritises depth through homogenous and purposive sampling and aims to accumulate knowledge with depth of experience through multiple studies across varied demographic groups (Smith et al., 2021).

Future research would benefit from exploring the experiences of self-compassion among adolescents from global majority ethnicities.

All participants were receiving support from CAMHS at the time of the study which presupposed a significant level of mental distress. Recruitment was facilitated via keyworkers which may have introduced selection biases. Keyworkers may have unconsciously selected participants they perceived as more willing to engage in research.

The researcher does not identify as autistic and therefore analysis may have misinterpreted autistic experiences, however, member checking of experiential statements mitigated this issue (Livingston et al., 2024).

Implications and Recommendations

The findings are most transferable to the autistic older adolescent however should be interpreted with caution due to limited depth concerning the processes embedded in the experience. Findings are therefore most useful for considering possible understandings of self-compassion from social contexts and how these experiences may impact therapeutic interventions.

Being Okay With Who You Are

Building a sense of self-esteem is a normative developmental challenge during adolescence, and therefore taking a flexible and accepting stance to mistakes may feel counterintuitive. Furthermore, autistic individuals typically preference dichotomous thinking. Psychoeducation about self-compassion may benefit from beginning with validating existing self-esteem concerns, and to further consider ways of transitioning from self-evaluating to self-soothing. This could include fostering reconnection with individual interests, outside of social evaluations, and setting achievement-based goals from a soothed state.

Therapeutic work could explore potential polarities between self-love and self-loathing. For example, positioning theory could be utilised to reflect about the way one positions themselves in relation to being likeable (Barratt, 2018). Many participants shared that being bullied impacted on their sense of self-compassion and their wellbeing. In doing so, they raised the importance of anti-bullying plans and compassionate cultures in education systems (Maratos et al., 2024; Welford & Langmead, 2015).

Feeling Understood, Seeking Connection

Participants emphasised that feeling understood by others was important in fostering self-compassion. CAMHS groups could be prioritised in response to local population needs, for example, group spaces could offer opportunities for shared understanding between autistic individuals, or those subjected to bullying (Floor & Lane, 2018).

Being Held Through the Suffering, and Sharing the Joys

Intervention could explore individualised ways of feeling safe and supported in suffering. For example, compassionate kitbags are a tool for calming the nervous system. The kitbag approach invites individuals to put together resources for soothing and tapping into compassion by using sensory and non-conversational cues (Lucre & Clapton, 2021). This could be completed collaboratively with caregivers.

Additionally, participants indicated the significance of co-regulation during distress. It may be helpful for psychologists to offer increasing support for teachers and caregivers regarding co-regulation and to manage any social expectations on autistic adolescents to self-regulate, particularly when experiencing low self-compassion.

The depictions of shared joy indicate the importance of access to social experiences where adolescents can safely explore their sense of self and cultivate positive emotion with others. Participants emphasised the significance of playfulness as a mechanism of

compassion. This could be empirically investigated in intervention studies. Several psychological interventions incorporate playfulness, such as *third wave* therapies and dyadic developmental psychotherapy (Carona et al., 2017; Hughes et al., 2015; Bombèr et al., 2020).

Ways of Treating Each Other, and Ourselves

The concept of self-compassion could be introduced as a quality to cultivate that needs the help of others. Conversations could prioritise how families and systems model self-care practices and invite conversations about learned ways of relating to self-care through the generations (Byng-Hall, 1986). It might help to start more conversations about what compassion looks like to foster shared ideas within the systems surrounding autistic adolescents. Ideas from participants in this study could be shared in CAMHS waiting rooms.

Conclusion

The study recruited seven 14–17-year-olds who shared their experiences of self-compassion, six of whom identified as autistic. Four group experiential themes were constructed. Participants placed emphasis on positive self-perception, intertwined with how others perceived them, and valued non-judgemental spaces in which to be themselves. Some participants resisted social norms when developing a sense of self-acceptance. Participants prioritised relational experiences such as feeling understood by others, feeling held during suffering, and sharing in playfulness.

Finally, participants emphasised ways of treating each other and themselves. They particularly focused on taking care of their health both physically and emotionally. Findings were most transferable to autistic adolescents experiencing mental distress, however, should be applied tentatively due to limitations in the study design. Overall, the findings illuminate adolescent understandings and lived experiences of self-compassion.

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Paper 3: Executive Summary

Word Count: 2561

Paper 3 has been written in the style of a report aimed at study participants, education providers and Child and Adolescent Mental Health Services (CAMHS). The report will be read by study participants, aged 14-17 years old, and therefore is stylistically aiming to be accessible to teenagers, many of whom identify as autistic.

Introduction

This is an “executive summary” of a research project carried out in a UK CAMHS service. This report is a way of summarising the research so that it can be read by the young people who generously gave their time to participate in the study (the participants) and families, schools and mental health services.

The research asked seven teenagers aged 14-17, “what does self-compassion mean to you?” Thank you very much to those participants for your interest in, and commitment to, this study.

Background

The importance of giving emotional support to children is widely known and it is a concern to education, social and healthcare professionals that increasingly, children are presenting with mental distress (Newlove-Delgado et al., 2023). UK National Health Service (NHS) surveys show a rise in referrals to CAMHS between 2017 and 2023 (NHS England, 2024; Children’s Commissioner, 2024).

Anxiety and depression increase from the age of 14 (Bluth & Blanton, 2015). At the same time, self-compassion decreases and so it’s important to understand more about how teenagers make sense of self-compassion. A relationship between self-compassion and distress does not necessarily mean that one causes the change in the other. There could be many other factors influencing this relationship.

Helping teenagers develop self-compassion to protect them from mental distress is a growing area of interest in psychology (Carona et al., 2017; Amari and Mahoney, 2022). Self-

compassion is sometimes helpful because experiences of compassion can help individuals to feel soothed and safe, which reduces psychological distress.

Human beings evolved within social networks, and therefore feeling connected to others, experiencing a sense of belonging and feeling cared for can all protect against feelings of threat and vulnerability (Gilbert & Irons, 2009).

Feeling threatened by other people, for example, by bullying, abuse, neglect, or rejection, makes it more likely that someone might feel ashamed and self critical (Gilbert et al., 2003). Worryingly, one in every four (25%) UK teenagers aged 12-18 years report they have been bullied, according to survey data from the year 2020 (Smith, 2020). They also reported experiences of anxiety and depression after being bullied.

A review of studies highlighted that psychology needs to further understand teenager experiences of developing a sense of self-compassion (Neuenschwander & Gunten, 2025). This includes what thoughts, feelings and experiences arise internally for teenagers when experiencing self-compassion, as well as how self-compassion grows through relationship experiences. This study hoped to fill a knowledge gap by exploring the development of self-compassion in teenagers' social contexts.

What is Self-Compassion?

Researchers have named five key aspects of compassion (Strauss et al., 2016):

A) recognition of suffering

B) awareness that suffering is universal, in other words, we all suffer

C) experiencing an emotional response to suffering

D) experiencing an acceptance of negative feelings

E) having a motivation to reduce the suffering.

Many researchers think of compassion as a brave and difficult thing to feel and do, like the act of a trained fire fighter who goes into a burning building even though it is risky,

because they have the training and skill to do so and they want to reduce the suffering of people inside the building (BalancedMinds, n.d; Gilbert, 2017).

Self-compassion from psychology's perspective means being kind to yourself, feeling connected to others because all humans suffer, and observing your thoughts and feelings during suffering without judging them (Neff, 2016). Self-compassion also needs a sense of acceptance of yourself, without criticism or comparison to others (Neff, 2003).

People often need help from other people to experience self-compassion. For example, receiving compassion from other people can increase your own sense of self-compassion (Brill & Nahmani, 2017). Compassion from others may be experienced in many ways, for example, through a comforting hug or someone listening to your experience without any judgement.

Self-compassion is an experience which, for all human beings, changes over time and across different situations. So, this research aimed to:

- deepen understanding of how self-compassion develops within the day-to-day lives of teenagers.
- give voice to the specific understandings about self-compassion, from the perspective of teenagers experiencing mental distress.

Method

The study took place within CAMHS in South Staffordshire, who are a multi-disciplinary team (MDT) supporting the social, psychological, and emotional development of children and young people aged 0-18 years (NHS England, 2024). Teenagers are often referred to CAMHS by family, caregivers or services who are concerned for them because of a severe expression of distress.

A youth advisory group called Think4Brum helped to plan the design of the project. The group expressed a preference for a research method which explored teenagers' experiences without giving a definition of self-compassion.

Once the design of the study was planned, ethical approval was granted (to make sure the project would not put anyone in harm) from the University of Staffordshire Ethics Committee Board and the National Health Service Research Ethics Committee and Health Research Authority.

Recruitment for the study took place between January 2025 and May 2025. Only teenagers aged between 14-19 and open to a CAMHS keyworker could take part. The study included several steps:

- Participants were invited to spend two weeks taking photos of, "what self-compassion means to you" based on experiences in their daily lives.
- Participants could complete this task independently or speak with a trusted person such as a family, friend or keyworker. They could also create artwork if they preferred.
- They brought their photos/artwork to a research interview. The researcher and participants talked about their photos and what was important to the participant about self-compassion.
- All interviews last around 60 minutes. The researcher focused on participant descriptions of what felt most important to share.
- Seven participants took part in the research. All participants agreed to taking part, having been told all the study information.
- Parents/caregivers also gave consent for participants aged 14-15 years.
- Interviews were audio recorded, and the researcher typed up each recording.

- The researcher interpreted the participant's explanation of their experiences with self-compassion (this was the analysis stage). Analysis started as soon as the first interview was documented.
- Analysis used a research method called, Interpretative Phenomenological Analysis (IPA) (Smith et al., 2021). Themes were created when an experience was spoken about across at least four of the seven interviews.

Participants

The average age of participants was 16 years, ranging from 14-17 years. Most participants identified as autistic. Four participants reported being diagnosed autistic, and two identified as autistic whilst they were on waitlists for an autism assessment.

Five participants completed the research task as planned, and one person created artwork. One participant forgot to do the research task but used photos available on his phone during the interview. One participant created a Pinterest board on their phone, instead of taking photos.

Findings

The findings reflect how the researcher made sense of what self-compassion means to participants. The researcher interpreted four key themes which are summarised below.

Being Okay With Who You Are

Five participants suggested that it felt important to feel okay about themselves, as they are. This consisted of three subthemes. Firstly, participants said that you need to develop self-love to be able to experience self-compassion. Quite a few participants shared that it is important to develop a sense of love for yourself, or at least like yourself. However, many

participants described difficulties with this. Some participants shared the challenge of liking yourself when you have been bullied by others.

Figure 1 is a painting created by one participant who summarises this experience. She shared that other people's negative comments are like "thoughts raining down onto" her sense of self-compassion.

Figure 1

"The Thoughts Raining Down Onto" Self-Compassion

-

Secondly, participants shared that non-judgemental spaces, where they feel listened to, helped them to feel more accepting of themselves as they are. Thirdly, they described that sometimes you need to say no to the expectations of other people, to feel okay about who you are without meeting social demands.

Feeling Understood, Seeking Connection

All the participants described moments when other people understood, or misunderstood, their experiences. Some participants felt misunderstood by school staff when

they did not adapt to their learning needs, or did not show understanding of their level of mental distress during the school day. They shared a wish for genuine understanding from people around them.

Many participants found it helpful to hear the stories of other people who had similar experiences to their own, however they also noted that peers do not typically talk about difficult experiences with each other at school. They highlighted the human need to feel understood by, and connect with, others.

Being Held Through the Suffering, and Sharing the Joys

Six participants described experiences of feeling supporting through their experience of suffering. Most of these experiences were alongside their pet animals, who seemed to recognise they were in emotional pain, and moved towards the participants.

Several participants described their pets sitting with them and comforting them during distress. Participants highlighted the vulnerability and risk of rejection when sharing negative experiences with other people. They seemed to value when other people quietly witnessed their suffering alongside them, perhaps offering affection, or offering them time to be together without a pressure to talk immediately.

They also described moments of shared laughter and joy with family and friends. Some participants felt moments of joy are an important escape from negative experiences. There was a sense from all participants that shared positive emotion felt like a compassionate moment.

Ways of Treating Ourselves and Each Other

Five participants felt that taking care of their physical or mental health is a type of self-compassion. Several participants highlighted how they valued support with self-care from those around them. Many participants also spoke about the significance of kind acts

from others. Participants hoped that the kindness they offer others would return to them and they emphasised their appreciation of the care they receive. Figure 2 is a participant painting which illustrates self-compassion radiating from within and “spreading the love”.

Figure 2

Self-Compassion Radiating From Within

Below are some participant quotes, exemplifying the four key themes.

I try not to listen to that because they, they aren't me. It's my body, I can wear what I want.

That you can only find it in yourself, if you love yourself, which is very hard to do if you hate yourself more than you love yourself.

It's just like not many people think about like how you feel or how you are in a situation and things.

It's about loving yourself…does anyone actually feel like that?

Yeah well it's kinder than just being delusional and saying that everything's great when it's not.

I think it's good to just know nobody is going to judge you, which helps with the self-compassion.

But it's almost it's seeing, like, characters, they almost feel like similar feelings. It's sort of a bit nice because I'm like, well, I'm not the only one who feels like this.

Keep healthy, keep your mind healthy, just that. And be kind to yourself and treat yourself as a person.

Like, the other day I lost the plot, broke down, self-harmed, and my dog wouldn't leave my side until I was all right, she was just next to me.

My mom? Yeah. She takes care of the dog, me, my sister. She's always there for us. Same thing goes for my sister.

Some people just want you to get it out and just talk to them, but [keyworker] will let you take your time.

Even if it's just a nice compliment. It can be nice. It can save someone. Someone could be so depressed, and you could be so nice to them and could save their life. It's just the little things that help.

We just laugh or just watch a movie or something. It's just fun. It's just nice to spend time with him [father].

My self-compassion is to help other people.

Discussion and Recommendations

Findings are most applicable to experiences of autistic teenagers accessing CAMHS, however, the chosen research methods were less helpful than hoped for investigating the processes of developing self-compassion. Nevertheless, the findings offer insights into teenage understanding and experiences of self-compassion.

The findings highlighted that it felt important to participants to develop a positive view of themself. This is similar to the perspectives of teenagers in a previous study conducted in Canada who shared the importance of feeling liked when exploring experiences of self-compassion (Klingle & Van Vliet, 2019). This study also adds a teenage focus on shared experiences of positivity, such as playfulness, as a pathway to self-compassion. Psychological definitions, on the other hand, talk about self-compassion as a way of coping with suffering. Participants in this study also emphasised feeling understood by others. Previous research did not highlight social connection through shared experiences of suffering. This difference may be because this study's participants were mostly autistic, and research suggests autistic individuals experience low self-compassion when feeling misunderstood.

Altogether, the findings highlight factors that clinicians can consider when encouraging self-compassion through therapeutic intervention. Several ideas are outlined below:

- Building a sense of self-esteem is a typical developmental challenge during adolescence. Teaching about self-compassion may work best when beginning with validating existing self-esteem concerns. Clinicians could think of ways to support teenager to shift away from critically evaluating oneself and towards self-soothing. This could include fostering reconnection with individual interests and setting achievement-focused goals from a soothed state.

- Therapeutic work could explore experiences of social interactions and how individuals are feeling about being liked or disliked by others (Barratt, 2018).
- Many participants shared that being bullied impacted on their sense of self-compassion and in doing so, they raised the importance of anti-bullying plans and compassionate cultures in schools and peer groups.
- CAMHS groups could be prioritised in response to local population needs, for example, group spaces could offer opportunities for shared understanding between autistic individuals, or those subjected to bullying.
- More conversations could be started about what self-compassion looks like, such as self-care, or how individuals expect to be treated by others. Ideas from participants in this study could be shared in CAMHS waiting rooms.
- Participants emphasised the significance of playfulness as a pathway to compassion. This could be further investigated in intervention studies; several psychological interventions incorporate playfulness.
- Intervention could explore ways of feeling safe and supported when feeling distress. Compassionate Kitbags are a tool which aim to promote soothing and a calming of the nervous system. The Kitbag approach invites individuals to put together resources for soothing and tapping into compassion by using sensory and non-conversational cues (Lucre & Clapton, 2021).
- It may be helpful for psychologists to offer increasing support for teachers and caregivers regarding co-regulation and to manage any social expectations on autistic adolescents to soothe their nervous system independently, particularly when experiencing low self-compassion.

Limitations and Future Research

There are key limitations to this study which need to be shared:

- Self-compassion is an abstract idea and there was no shared definition in this study. This limited explorations of the processes of how self-compassion develops.
- Autistic participants may have benefitted from more support than was planned for to access emotions and thoughts about self-compassion during research interviews.
- Not all participants used photos from the suggested two-week period during the study. This may mean that some participants were drawing more on memories, rather than current experiences of self-compassion in their day-to-day lives.
- Most participants identified as White British. Future research should explore the experiences of self-compassion among adolescents from global majority ethnicities.
- Keyworkers may have invited participants they saw as more likely to engage in research at the time of the study.
- The researcher does not identify as autistic and therefore may have misinterpreted some experiences, however, most participants checked the researcher's analysis which reduced this issue (Livingston et al., 2024).

Conclusion

Self-compassion did not seem to be widely spoken about in the lives of teenagers. The seven participants who took part illuminated how they understand self-compassion from their experiences. They highlighted that adolescence is a key time for developing a positive way of thinking about oneself. Participants emphasised a need for non-judgemental spaces in which to explore being themselves. Some participants said no to the way things are normally done, like choosing your own clothing style, and most prioritised relational experiences such as feeling understood by others, feeling held during their suffering, and sharing in laughter and playfulness. In doing so, participants suggested self-compassion is as much about positive shared experiences as it is about feeling understood during painful experiences.

The way one treats themself and others, and how one is treated in return, was another central aspect. Participants felt a responsibility to take care of their physical and mental health but shared that this can be very challenging to do and valued caring responses from others. A thread throughout the findings was the adolescents' focus on experiences in relationships. Overall, findings highlighted the importance of supporting teenagers to bridge the gap between critically evaluating themselves and finding a state of soothing and calmness.

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List of Appendices

Appendix A

Review Journal of Autism and Developmental Disorders: Submission Guidelines

Review Journal of Autism and Developmental Disorders

Contents

Appendix B

Data Extraction Table

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
Edwards et al., 2024	Australia	-To explore autistic experiences of completing a co-produced self-guided program: Aspect	Qualitative (following intervention)	Autistic adults who had completed ASPAA and scored low to moderate on the self-compassion scale (SCS) pre-intervention.	N=39	18+ only Mage = 45.28, SD age = 11.92.	Female (N=28), Male (N=5), Non-binary or Agender (N=6)	White (N=38) 'Mixed' (N=1)	Professional diagnosis (N=30) Self-identified (N=9) & AQ-short score above cut off (65)	Self-Compassion Scale (SCS) Pre-intervention mean = 2.14 (SD = 0.47), range = 1.19 to 3.23. Post-intervention mean = 2.98	A co-produced self-guided compassion program for autistic adults (ASPAA)

[1] Operationalisation of autism and participant representation.
[2] Operationalisation of self-compassion and participant scores on the self-compassion scale.

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		Self-Compassion Program for Autistic Adults (ASPAA). --To investigate unintended		Exclusion criteria: -Learning disability -Diagnosis of psychosis -Suicidal ideation/behaviour -Recent initiation or cessation of						(SD = 0.54), range = 2.12 to 4.23.	

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		consequences of ASPAA.		psychotherapy or psychiatric medication -No access to necessary technology							
Wilson et al., 2022	UK	To explore autistic women's experienc	Qualitative	Autistic adults (female, cisgender only) with a	N=11	18+ only Age-range = 35-69 years	Cisgender Female (N=11)	White British (N=10) White (N=1)	Professional diagnosis after 18th	Neff's definition – no measure utilised.	N/A

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		es of being self-compassionate following diagnosis of autism and more widely in their lives.		clinical autism diagnosis received after their 18th birthday. Exclusion: -Lacked capacity to consent		Mean and SD not reported.			birthday (N=11)		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
				-Unable to speak English -No access to the internet							
Riebel et al., 2024	France	Investigating whether and how self compassion scores	Single case pre-experimental design	One male with a formal diagnosis of autism, a score above 2.5 on the	N=1	41 yrs.	Male (N=1)	Unreported.	Professional diagnosis (N=1)	Self-Compassion Scale (SCS) Score unreported. Large	Compassion focused therapy

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		improve following compassion focused therapy (CFT) and relationship to changes in self-stigma		internalised stigma of mental illness (ISMI-9), and an IQ within normal range.						increase in Tau-U (0.99) post intervention.	

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		and shame.									
Galvin et al., 2024	UK	To establish whether camouflaging and self-compassion levels are correlated	Correlation	Autistic adults Exclusion criteria: -Learning disability -Failed survey attention checks	N=294	18+ only Mage = 30.53, standard deviation = 12.57. Range 18–65.	Males N = 142 Female, N = 152	White (78%), Asian (10%), Black (9%), Mixed (2%).	Self reported diagnosis and Autism Spectrum Quotient (AQ)-short scores	Self-Compassion Scale (SCS) Mean = 2.26 SD= 0.68 Range = 1.08 to 4.25	N/A

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		in autistic adults; and investigate any influences on mental distress.							ranged from 12 to 28. Scores 16+ (86%, N = 252) The Camouflaging		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
									Autistic Traits Questionnaire (CAT-Q) Mean = 118.91 Standard Deviation SD = 25.04 Range = 25 to 175		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
Galvin et al., (2023)	UK	To estimate the effects between autistic traits, self-compassion and symptoms of anxiety and	Correlation - 12-month three-wave cross lagged panel design.	Autistic and non-autistic adults	Autistic adults: N = 228 at T1, N = 156 at T2, and N = 165 at T3	Autistic Participants: Baseline (T1) Mean = 30.5, SD = 9.47, range = 18–60	Unreported but surveyed for equal male/female ration	Autistic participants: White (87.3%), Asian/Asian British (3.9%), Mixed (3.9%), Black/Black British	The Autism Spectrum Quotient (AQ) Autistic Participants T1: Mean	Self-Compassion Scale (SCS) Autistic adults: Baseline (T1) Mean = 2.15, SD = 0.65; 6 Months (T2):	N/A

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		depression across three time points.			Nonautistic adults: N = 228 at T1, N = 122 at T2, and N = 124 at T3	Non-autistic participants: Mean = 33.1 SD = 11.07 Range = 19–69		(3.1%), Middle/ Near Eastern (1.3%), and Hispanic or Latino (0.4%) Nonautistic participants: White (85.5%),	33.95, SD = 8.38 T2: Mean = 35.69, SD = 8.28 T3, Mean = 35.94, SD = 8.63	Mean = 2.20, SD =0.67; 12 Months (T3) Mean = 2.18, SD= 0.66 Non-Autistic Adults: Baseline (T1) Mean = 2.75, SD= 0.60; 6 Months (T2)	

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
								followed by Asian/Asian British (8.8%), Black/Black British (2.6%), Mixed (1.8%), Black Other (0.4%), Middle/Near Eastern	Participants T1 : Mean = 20.23, SD = 7.61 T2 : 21.62, sd = 8.59 T3 : Mean = 22.35, SD =9.01	Mean = 2.78, SD =0.62; 12 Months (T3) Mean = 2.76, SD=0.61	

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
								(0.4%), and Hispanic or Latino (0.4%)			
Cai et al (2024)	Australia	To assess feasibility, acceptability and outcomes concerning emotion regulation	Interventional (pilot study) – pre and post outcome data, and qualitativ	Autistic adults who had completed a co-produced self-guided program for autistic adults	N=39	18+ only Mage = 45.28, SD age = 11.92.	Female (N=28), Male (N=5), Non-binary or Agender (N=6)	White (N=38) Mixed (N=1)	Professional diagnosis (N=30) Self-identified (N=9) &	Self-Compassion Scale (SCS) Mean = 2.14 (SD = 0.47), range = 1.19 to 3.23.	A co-produced self-guided program for autistic adults

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		and mental health of autistic adults; of a pilot, online self-compassion Program (the Aspect	e feedback (qualitative component does not meet criteria for MMAT mixed methods).	(ASPAA) and who had scored "low" to "moderate" on the Self Compassion Scale pre-intervention. Exclusion criteria: current or					AQ-short score above cut off (65)	Post-intervention SCS Scores: mean = 2.98 (SD = 0.54), range = 2.12 to 4.23.	(ASPAA)

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		Self-compassion Program for Autistic Adults, ASPAA).		lifetime psychosis diagnosis, current suicide ideation or behaviour, recent initiating or cessation of psychiatric medication or therapy.							

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
Cai et al (2023)	Australia	To investigate whether emotion regulation mediates the relationship between self-compassion and	Correlation – Pearsons' r and simple mediation analysis to test the indirect effects of	Autistic adults (self report or clinical diagnosis)	N=153	Mean age = 35.70, SD age = 12.62 Range 18–75	Female = 63%, Male = 27%, Nonbinary = 9%, Other/don't want to say = 1%)	White (82%), followed by Asian (7%), Pacific Islander (5%), and Hispanic (4%).	Self reported professional diagnosis N = 114, 75% at a mean age of 30 yrs SD= 16.32, age range	Self-Compassion Scale (SCS) Mean = 2.50 SD 0.67 Range = 1.08 to 4.25	N/A

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		anxiety or depression in a sample of autistic adults.	the models.						3–72 yrs including: ASD (n = 59; 52%), Asperger's syndrome (n = 21; 18%), autism or autistic disorder		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
									(n = 23; 20%), pervasive developmental disorder, not otherwise specified (n = 10; 9%), and childhood		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
									disintegrative disorder (n = 1; 1%). Self-identified and scored above cut off score on AQ-		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
									short (N=39)		
Cai, Gibbs et al (2022)	Australia	To investigate self-compassion experiences of autistic individuals and associatio	Convergent mixed methods design. Survey and 11 autistic participants were	Autistic and non-autistic adults.	Total N=246 Autistic adults (N=153) Non-autistic adult N- 93	Autistic adults Mage = 35.70, Sdage = 12.62 18 to 75 years Non-autistic	Autistic Female N= 97 (63%), autistic Autistic Male N = 41 (27%), Autistic non-	White N=126(82%) Asian N=10 (7%) Multiethnicity N=9 (6%) Pacific Islander N=8 (5%)	Self-identified Autistic M=82.43; SD=9.76; range=67–106). All scored above cutoff score.	Self-Compassion Scale (SCS) Autistic Adults: Mean SCS Score: 2.14 Standard Deviation (SD): 0.47	N/A

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		ns with clinical levels of mental distress.	interviewed.			adults aged Mage = 39.37, Sdage = 9.99 23 to 72 years	binary N=14 (9%), Autistic Other N= 1 (1%).	Hispanic N=6 (4%) Africa N=4 (3%) Aboriginal N =2 (1%) Torres Strait Islander N=2 (1%) Middle Eastern N=2 (1%)	Self-reported professional diagnosis with AQ-short scores of: M=84.80; SD=11.77 range=55 –105	Range: 1.19 to 3.23 Non-Autistic Adults: Mean SCS Score: 2.98 Standard Deviation (SD): 0.54 Range: 2.12 to 4.23	

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
									The AQ-Short scores of autistic participants (M=84.22; SD=11.33) were significantly higher		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
									than the non-autistic participants (M=50.98; SD=7.36), U=76, z = -13.00, p<.001, r=.83.		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
Hartley (2022)	UK	To explore autistic adults attitudes towards themselves, and factors influencing their response to	Qualitative	Autistic adults. Exclusion: Lacked capacity to consent to participate 17 years or younger Unable to speak fluent English.	N=15	Age range: 20-69. Exact ages were redacted to protect confidentiality.	Female N=9 Self-identified as neutral N=1 Male N=5	White other N=2 White British N=13	Professional diagnosis of Autistic Spectrum Disorder. Participants were recruited from the Sheffield Autism	Self-Compassion Scale (SCS) Mean = 2.35 SD = 0.55 Range 1.50 to 3.80	N/A

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		challenges. And to explore their perceptions of helpful and hindering factors concerning their ability to							Research Lab (ShARL), a database of autistic adults who have consented to being contacted to be invited to take part		

Author, Year	Country	Aim	Study type	Population	Sample size	Age (years)	Gender	Ethnicity	Autism[1]	Self-compassion[2]	Intervention
		be self-compassionate.							in research.		

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
Edwards et al., 2024	Anxiety N= 28 (72%) Depression N= 26 (67%) Speech or language impairment N= 2 (5%) ADHD N=12 (31%) OCD N=4 (10%) Sensory processing	Reflexive Thematic Analysis	-Positive and negative affect schedule (PANAS) -Difficulties in Emotion Regulation Scale (DERS) -The Diagnostic and	N/A	- Practicing self-compassion can be difficult and emotional - self-criticism, more critical of self than others - little insight into feelings - difficult to label feelings - difficult to keep focus on practices	The study predominantly recruited white females, with university level education; technology requirements were a barrier to wider participation.	-comprehensive evaluations of the autistic experience of intervention - further research to investigate wellbeing outcomes of ASPAA, and other self-compassion interventions

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	disorder N=4 (10%) Seizure disorder (epilepsy) N=2 (5%) Other N=12 (31%) No co-occurring conditions N=3 (8%)		Statistical Manual of Mental Disorders-5 Generalized Anxiety Disorder Dimensional Scale (DSM-5 GAD-D) -Patient Health Questionnaire-9 (PHQ-9)		- difficult to maintain regular practice due to mental effort - exercises inappropriate to individual's sensory profile e.g. *soles of the feet / progressive muscle relaxation*. - some did not agree with cognitive		- research using larger and more diverse samples, incorporating RCT's.

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
			-The Warwick–Edinburgh Mental Well-being Scale (WEMWBS)		exercises e.g. 5-4-3-2-1 exercise. - triggering of painful memories - negative comparing self comparison to others in the intervention lived experience videos - limited reassurance that they are ‘on the		

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					right track' with the exercises - prescriptive exercises; participants valued flexibility to authentically find what works for them.		
Wilson et al., 2022	Depression (N=not reported) Anxiety (N= not reported)	Interpretative Phenomenological Analysis (IPA)	N/A	N/A	-Autism misunderstood and stereotyped - Feeling different from / wrong	-All participants identified as white ethnicities	- Investigate effectiveness of self-compassion intervention for autistic women

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	Dyspraxia (N= not reported)				compared to others / less than others in society - Difficulties navigating social rules -Pressure to conform - Negative messages about autism in Applied Behavioural Analysis	-Research on socioeconomic status was not collected.	- Investigate self-compassion perspectives of other ethnicities concerning autistic populations.

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					- Rejecting views of others - Experience of victimisation - Interpersonal difficulties - Seeking external validation - Masking - Isolation - Fear of self-compassion as over-indulgent		

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					- 'Striving traits' ie. to be accepted by society - Diagnosis later in life/into adulthood		
Riebel et al., 2024	Social anxiety Asthma	Visual Analysis Comparison between baseline and treatment	Internalised stigma of mental illness (ISMI-9). Daily reports of the feeling of shame.	-Self-compassion increased whilst shame decreased across baseline and problem conceptualisatio	- Social stigma about autism	-A-B design not true experimental., & the conceptualizati on phase can be either seen as part of the	-Study replication with a larger sample and diverse experiences of autism

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
				n. -Self-compassion increased throughout the conceptualization, CFT and follow-up phases.		baseline or the intervention - A focus on effective aspects of the intervention, with less attention to barriers to development of self-compassion. - Only examples of	

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
						Julian's diary entries; the addition of a qualitative analysis may have provided more details on processes from Julian's perspective ie. barriers and enablers.	

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
Galvin et al., 2024	Anxiety (52% diagnosed, 14% suspected), Depression (54% diagnosed, 15% suspected), Obsessive compulsive disorder (OCD) (12% diagnosed, 19% suspected) Attention-deficit/	-Pearson's correlations -A series of serial multiple mediation models (PROCESS model 6), with bias-corrected bootstrapping (10,000 resamples)	Generalized Anxiety Disorder-7 Scale (GAD-7) The Patient Health Questionnaire-9 (PHQ-9) The Liebowitz Social Anxiety	N/A	-A negative correlation existed between social camouflaging and self-compassion (rpartial = -0.483, $p < 0.001$). -Autistic participants with higher autistic traits attempted to camouflage these traits more in	-Autism diagnosis was self-report -Cross-sectional study means causal inferences can not be made.	- Interventions targeting self-compassion or camouflaging may not be as effective (for mental health outcomes) as targeting both simultaneously. - Promotion of autism acceptance

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	hyperactivity disorder (ADHD) (18% diagnosed, 20% suspected).		Scale (LSAS) 31		social situations. This was associated with reduced self-compassion. - Stronger associations were observed for the camouflaging to self-compassion indirect pathway (compared to the self-compassion to		- Develop interventions to target the relationship between camouflaging and self-compassion ie adapt CFT exercises to incorporate autistic social experiences.

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					camouflaging indirect pathway) (range b = 0.06–0.09), accounting for between 20% and 23% of the total effect of autistic traits on mental health outcomes.		-Future research with more diverse samples - More longitudinal research
Galvin et al., (2023)	Autistic participants: Diagnosis of	Correlational - Four cross-lagged models	Hospital Anxiety and Depression	N/A	- Earlier anxiety and depression did not predict	-The study relied on an online survey&	- Investigate the biopsychosocial factors which

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	anxiety N=157 (68.9%), Depression N= 140 (61.4%) Obsessive compulsive disorder (OCD) N= 32 (14%) Attention deficit hyperactivity disorder (ADHD) N= 42 (18.4%).	were tested in each group	Scale (baseline, 6 months, & 12 months)		subsequent self-compassion. -Autistic traits predicted later reduced self compassion.	self reported autism diagnoses. -Reliance on self-report questionnaires, with potential response bias -Attention check questions were created by the authors for the purpose of this study, but	explain the relationship between autistic traits and later reduced self compassion. - Examine self-compassion alongside other previously established mediating factors, such as alexithymia and

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	Self identified anxiety = 44 (19.3%), Depression= 39 (17.1%) OCD = 59 (25.9%) ADHD= 62 (27.2%). Non autistic participants: Diagnosis of anxiety N= 62 (27.2%)					these have not been previously validated -Small sample size -Exclusion of individuals with an intellectual disability limits the generalisability of the findings.	emotion regulation - Investigate self-compassion and intersectionality. - Control for pre-existing therapeutic knowledge of self compassion.

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	Depression N= 61 (26.8%) OCD N=3 (1.3%) ADHD N= 4 (1.8%). Self-identified anxiety N= 64 (28.1%) Depression N= 43 (18.9%), (9.2%), OCD N = 31 (13.6%)					- Limited diversity of participants - No information on participants' knowledge and understanding of self-compassion.	

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	ADHD N= 33 (14.5%).						
Cai et al (2024)	Anxiety N= 28 (72%) Depression 26 (67%) Speech or language impairment 2 (5%) ADHD 12 (31%) OCD 4 (10%)	Recruitment and attrition data (feasibility) Descriptive responses on acceptability items were reviewed Quant:	5-point likert scale to assess acceptability. Positive and Negative Affect Schedule (PANAS)	-Statistical increases in self-compassion ($M_{diff}=-0.85$, $SD_{diff}=0.58$), $t(38)=-9.14$, $p<0.001$, $\eta 2=0.69$, with large effect size. --Effect sizes of improvements	-21 participants (54%) reported experiences of backdraft. Mostly for Loving kindness meditation and feeling the soles of your feet. Backdraft included	- Small sample - No randomization or control condition. - no co-occurring intellectual disability reduces generalisation	-Investigate individual practices of self-compassion to better understand unwanted effects -Conduct an RCT of ASPAA -Test the outcome of individual self-

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	Sensory processing disorder 4 (10%) Seizure disorder (epilepsy) 2 (5%) Other 12 (31%) No co-occurring conditions 3 (8%)	A paired-samples t-test on participant scores on the SCS Paired-sample t-tests were conducted on participants' scores on the PANAS,	Difficulties in Emotion Regulation Scale (DERS) The Diagnostic and Statistical Manual of Mental Disorders-5 Generalized	strongest for self-compassion, emotion regulation, and psychological well-being.	unpleasant emotions and self criticism when first practising loving kindness meditation. - *Soles of the feet* backdraft did not improve after the initial try. Negative physiological reaction to focusing on their	-Self report outcome measures - no follow ip measures -more autistic women volunteered to participate in this study than autistic adults of other gender identities.	compassion practices -Examine the impact of past traumatic experiences of stigma and bullying on self-compassion levels.

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
		WEMWBS, DSM-5 GAD-D, PHQ-9, and DERS. Missing items (four data fields of two participants, two for DERS and two DSM-5 GAD-D) were addressed using linear interpolation method.	Anxiety Disorder Dimensional Scale (DSM-5 GAD-D) Patient Health Questionnaire-9 (PHQ-9) The Warwick–		feet continued e.g. chronic pain, don't like touch on feet.		

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
		Reviewed the weekly 'catch-up notes' and identified the number of participants who provided feedback referencing backdraft (self critical thoughts, thoughts, unpleasant	Edinburgh Mental Well-being Scale (WEMWBS) Weekly catch ups				

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
		emotions associated with doing the practices, or painful bodily sensations).					
Cai et al (2023)	Anxiety disorder (58%), Mood disorder (48% Attention-deficit/hyperactivity disorder (27%)	-Pearson's r correlations investigated associations with exclude cases pairwise and bias-corrected	Emotion Regulation Scale (DERS) Diagnostic and Statistical	N/A	-Self-compassion was weakly and negatively associated with anxiety and depression and strongly and negatively	- Self report autism diagnoses - Findings are correlational and causal relationships	Further research to investigate how self-compassion interventions can be tailored to autistic needs and preferences.

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	Sensory processing disorder (14%) Obsessive compulsive disorder (12%) Speech or language impairment (10%) Learning impairment (6%).	bootstrapping (2000 resamples) to account for the non-normal distributions of variables. Four simple mediation analyses were also utilised, to test indirect effects of the models.	Manual of Mental Disorders-5 Generalized Anxiety Disorder Dimensional Scale (DSM-5 GAD-D) Patient Health Questionnaire-9 (PHQ-9)		correlated with emotion dysregulation. - Emotion regulation mediated the relationship between self-compassion and anxiety, b=-0.18, 95% CI (-0.25 to -0.12).	can't be inferred - Sampling bias: more women volunteered to participate - the study's results may not be generalizable to autistic adults with co-occurring	

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					- Emotion regulation mediated the relationship between self-compassion and depression R2 = 0.43, F(1,150) = 113.14, p < 0.001, and the indirect effect was also statistically significant, b=-	intellectual disability or those without higher education experience.	

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					0.14, 95% CI (-0.20 to -0.09).		
Cai, Gibbs, Love et al (2023)	Anxiety disorder (58%), Mood disorder (48%), Attention-deficit/hyperactivity disorder (27%), Sensory processing disorder (14%),	Mann-Whitney U tests to investigate self-compassion levels, positive psychological wellbeing, and symptoms of anxiety and depression across autistic	DSM-5 GAD-D PHQ-9 Warwick-Edinburgh Mental Wellbeing Scale.	N/A	-Self-reported self-compassion scores of autistic participants were significantly correlated with age (r=−.35, p<.001), highest level of education (r=−.44, p<.001), and autism traits (r=−.31, p<.001).	Cross-sectional design does not infer causal relationships between the constructs. More female participants in both autistic and non-autistic groups.	-Future research investigating gender differences in self-compassion levels across gender identities concerning autistic populations. -Investigate whether self-

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
	Obsessive compulsive disorder (12%), Speech or language impairment (10%), Learning impairment (6%).	and non-autistic groups. Spearman Rank order correlations investigated associations between self-compassion and demographic variables and mental health outcomes.			-Age (beta=−0.16, p=.042) and autism traits (beta=−0.34, p<.001) were statistically significant predictors of self-compassion in autistic participants. Interviews:		compassion intervention can improve the mental health outcomes of autistic adults.

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
		Linear regressions investigated the demographic predictors of self-compassion levels in autistic and non-autistic participants. Qualitative interviews: reflexive			-participants were often self-critical., often in work and social situations; -identified with their emotions; -felt disconnected from non-autistic people; -struggled to be objective observants of their own thoughts and feelings;		

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
		thematic analysis.			-felt their inner experiences were not shared with other people, especially people not on the autism spectrum.		
Hartley (2022)	Unreported.	Reflexive thematic analysis	N/A	N/A	-Non-acceptance/rejection from others in childhood -Attributing blame and responsibility	-Most participants were white British -Most participants	- investigating experiences of autistic individuals diagnosed during childhood

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					on self after difficult social experiences, and pressuring self to change and fit in. -Late autism diagnosis in adulthood, resulting in limited self-understanding -Difficulties with emotion recognition	received a diagnosis later in life -Most engaged in higher education -Sample was also predominantly women -Lead researcher is not autistic,	-Working towards earlier diagnosis, reduced waiting times and timely referrals. -Education on autism in the national curriculum to promote autism acceptance. -Policies to support

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					-Feeling their difficulties were unique or more severe than others -Other autistic people hiding their struggles making it difficult to recognise they are not alone. -Overwhelming emotional empathy	double empathy problem	employers to welcome neurodiverse employees. -Service to support family/carers to offer a kind and caring approach. -Professionals modelling celebration of neurodiversity

Author, Year	Co-occurring health issues	Analysis	Other measures	Intervention change in SCS	Barriers	Limitations	Recommendations
					-Pressure to sacrifice one's on needs -Ruminating on flaws -Other people modelling criticism and disapproval -Loneliness in social withdrawal		and strength based approaches -Intervention to support blame and shame reduction concerning autistic individuals.

Appendix C

MMAT Quality Appraisal

Author(s)	Qualitative	Quantitative (RCT's)	Quantitative (non-randomised)	Quantitative (descriptive)	Mixed methods	Comments	Score
Riebel et al., 2024		ü	ü				*****
Cai et al., 2024						Confounders not accounted for.	****
Cai, Gibbs, love, et al., 2023						Risk of sampling bias.	****

Author(s)	Qualitative	Quantitative (RCT's)	Quantitative (non-randomised)	Quantitative (descriptive)	Mixed methods	Comments	Score
Galvin et al., 2024						Risk of sampling bias.	****
Cai et al., 2023						Risk of sampling bias. Confounders not accounted for.	***
Galvin et al., 2023						Risk of sampling bias.	****

Author(s)	Qualitative	Quantitative (RCT's)	Quantitative (non-randomised)	Quantitative (descriptive)	Mixed methods	Comments	Score
Hartley, 2022							*****
Edwards et al., 2024							*****
Wilson et al., 2022							*****

Appendix 3: MMAT Scoring Guidelines (Hong et al., 2018)

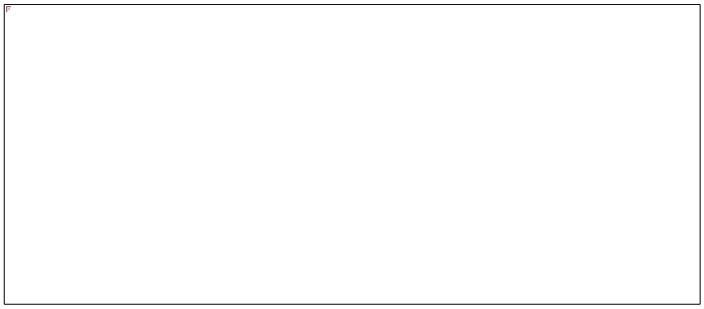
Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Co
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Appendix D

American Journal of Qualitative Research Submission Guidelines

AMERICAN JOURNAL OF QUALITATIVE RESEARCH



Author Guidelines

Manuscript Submission Guidelines: American Journal of Qualitative Research (AJQR)

Only manuscripts of sufficient quality that meet the aims and scope of the **American Journal of Qualitative Research** will be reviewed.

As part of the submission process, you will be required to warrant that you are submitting your original work, that you have the rights to the work, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere, and that you have obtained and can supply all necessary permissions for the reproduction of any copyright works not owned by you.

Supplemental Material

American Journal of Qualitative Research adheres to the APA reference style (7th edition). Please review the APA style to ensure your manuscript conforms to this reference style.

- Manuscripts submitted for review are expected to be free from language errors and must be written and formatted strictly by following the latest edition of the APA style.
- Online submission of manuscripts is mandatory for all types of paper.
- Manuscripts must be in Microsoft Word format only.
- If you are comfortable using templates (strongly recommended), use the following link for the manuscript template before your submission.

  https://www.ajqr.org/files/208/ajqr-word-template.docx

- If you use EndNote to manage references, you can download the APA output file here.

Reference Style

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using **AJQR** Language Services.

Submission Preparation Checklist

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

1. The submission has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).
2. The submission file is in OpenOffice, Microsoft Word, RTF, or WordPerfect document file format.
3. Where available, URLs for the references have been provided.
4. Submissions to the journal should be submitted with double-space in Times New Roman font, 12-point type, formatted as 8.5" x 11" pages with (Top:2,5 cm, Bottom:2 cm, Left:2,5 cm, Right:2,5 cm) margins on all sides. Authors should include appropriately formatted subheadings at reasonable intervals. Pages should be numbered consecutively. All abbreviations should be spelt out on their first use except for commonly-known abbreviations. For Research Articles, the total length should typically be 6,000 to 10,000 words (excluded tables, figures, and references). For Notes from the Field, the total length should typically be 2,000 to 3,000 words. For Book Reviews, the total length should typically be 1,500 to 2,500 words. All illustrations, figures, and tables are placed within the text at the appropriate points, rather than at the end.
5. All submissions must include an abstract of 150-300 words and 3-6 keywords. These should be included in the manuscript file in APA 7 style.
6. Manuscripts submitted for review must be anonymized, which means authors will need to remove all potentially identifying information. Outside of the separate title page file mentioned above, submitted finals should not identify the authors, their affiliations, their funding sources, or other information that might identify authors. Authors should also anonymize any self-citations in the manuscript following APA style requirements. Self-citations only need to be anonymized if it might be apparent to reviewers that it is a self-citation.
7. The reference list should only include sources cited in the manuscript, and all sources cited in the manuscript must be included in the reference list. All references should include digital object identifiers (DOI) when possible, and all references must comply with APA style, 7th edition.
8. Tables and figures may be included in APA style, 7th edition formatting.
9. All manuscripts must be submitted in English.
10. Authors who wish to include copyrighted material must submit documentation of permission to use copyrighted materials.
11. If submitting to a peer-reviewed section of the journal, the instructions in Ensuring a Blind Review have been followed.

Alert: Starting in 2020, the **American Journal of Qualitative Research** will transition to the APA 7th edition style guide for publications and will expect that at least one author has an ORCID iD.

ORCID iDs: All published articles must include an **ORCID iD** for at least one author, preferably the first author (see APA 7 ed. Section 2.7). The **open researcher and contributor identifier** (ORCID) is a free, 16-digit, linkable, persistent **digital identifier** (iD) that helps

keep individual researchers distinguished from one another, *especially* other researchers who may have the same name. Authors may want to read What is ORCID before registering for one.

Privacy Statement

The names and email addresses entered in this journal site will be used exclusively for the stated purposes of this journal and will not be made available for any other purpose or to any other party.

Artificial Intelligence

We at AJQR recognize the value of artificial intelligence (AI) and its potential to help authors in the research and writing process. We also welcome advancements in this area to enhance opportunities for generating ideas, accelerating research discovery, synthesizing, or analyzing findings, polishing language, or structuring a submission. Lastly, we value accuracy, transparency, and integrity in the research and writing process.

To comply with this policy, authors

- must disclose their use of AI and AI-assisted technologies in the body of the submission.
- must not list Generative AI as an author of the submission.
- should cite original sources, rather than Generative AI tools as primary sources within the reference.
- must not use AI to create or manipulate images and figures.
- must disclose on the AJQR submission page their use of any Generative AI or AI-assisted technologies in the research process reported in this submission including the creation of the report itself. In the disclosure, authors must name the tool, describe how it was used, and the reason for using it.

While submissions will not be rejected because of the disclosed use of Generative AI or AI-assisted technologies, if an editor becomes aware that Generative AI or AI-assisted technologies was inappropriately used in the preparation of a submission without disclosure, the editor reserves the right to reject the submission at any time during the publishing process. Inappropriate use of Generative AI includes the generation of incorrect text or content, plagiarism, or inappropriate attribution to prior sources.

e-ISSN: 2576-2141

Appendix E

Ethical Approval

South West - Cornwall & Plymouth Research Ethics Committee

2 Redman Place

Stratford

London

E20 1JQ

Telephone: 02071048071

08 November 2024

Ms Charlotte Cochrane

Science Centre, Leek Road, Staffordshire University

ST42DF

Dear Ms Cochrane

Study title:	**How do older adolescents experiencing mental distress make sense of the concept of self-compassion; exploring socio-cultural influences through a photo elicitation and interpretative phenomenological analysis study.**
REC reference:	**24/SW/0090**
IRAS project ID:	**339818**

Thank you responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

registering research studies

reporting results

informing participants

sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a public registry before the first participant is recruited and no later than six weeks after. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

A 'public registry' means any registry on the WHO list of primary registries or the ICMJE list of registries provided the registry facilitates public access to information about the UK trial.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

Where a deferral is agreed we expect the sponsor to publish a minimal record on a publicly accessible registry. When the deferral period ends, the sponsor should publish the full record on the same registry, to fulfil the condition of the REC favourable opinion.

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Where the study is registered on ClinicalTrials.gov, please inform deferrals@hra.nhs.uk and the Research Ethics Committee (REC) which issued the final ethical opinion so that our records can be updated.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter. Where a deferral is agreed, a minimum research summary will still be published in the research summaries database. At the end of the deferral period, we will publish the full research summary.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: Research summaries - Health Research Authority (hra.nhs.uk)

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments

Adding new sites and investigators

Notification of serious breaches of the protocol

Progress and safety reports

Notifying the end of the study, including early termination of the study

Final report

Reporting results

The latest guidance on these topics can be found at Managing your approval - Health Research Authority (hra.nhs.uk)

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Recruitment video adolescent]	V1	20 May 2024

Copies of materials calling attention of potential participants to the research [CAMHS keyworker consent to contact form with instructions]	1.4	30 October 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Employer's Liability and Public and Product Liability]		
Interview schedules or topic guides for participants [Topic guide]	V1.2	20 May 2024
Interview schedules or topic guides for participants [Demographic questions]	V1.2	20 May 2024
IRAS Application Form [IRAS_Form_02082024]		02 August 2024
Letter from sponsor [Letter from the Sponsor]		21 May 2024
Other [Professional Indemnity Insurance]		01 August 2023
Other [GCP certificate]	N/A	30 November 2023
Other [Photo elicitation instruction sheet]	V1.2	20 May 2024
Other [Online safety information sheet for parents/guardians]	V1.2	30 October 2024
Other [Participant online safety information sheet]	V1.2	30 October 2024

Other [Mental health support signposting sheet]	V1.2	30 October 2024
Participant consent form [Consent form aged 16-18]	V1.3	02 July 2024
Participant consent form [Parent/guardian consent form V1.0 22.07.24]	V1.0	22 July 2024
Participant consent form [Participant assent form (aged 14-15)]	V1.0	22 July 2024
Participant information sheet (PIS) [Adolescent PIS]	1.6	30 October 2024
Participant information sheet (PIS) [Parent/guardian PIS]	1.5	30 October 2024
Research protocol or project proposal [Research Proposal]	V1.4	30 October 2024
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	V1	24 June 2024
Summary CV for student [Chief Investigator CV]	V1	24 June 2024
Summary CV for supervisor (student research) [Supervisor CV]	v1	26 April 2023
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Protocol flow chart]	V1.2	01 July 2024

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: Quality assurance - Health Research Authority (hra.nhs.uk)

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: Learning - Health Research Authority (hra.nhs.uk)

IRAS project ID: 339818 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Sharon Northey

Approvals Manager

pp Dr Stephen Coles Chair

Email:cornwallandplymouth.rec@hra.nhs.uk

Enclosures: "After ethical review – guidance for Researchers"

Non CTIMP Standard Conditions of Approval

Copy to: Dr Sarahjane Jones

Lead Nation: approvals@hra.nhs.uk

Appendix F

Mental Health Signposting Sheet

NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

STAFFORDSHIRE UNIVERSITY

Local mental health support

If you need mental health support during the research project, please contact your CAMHS keyworker Monday-Friday 9am-5pm. If you need urgent help outside of 9-5pm hours, you can call for support on the numbers below.

24/7 HELPLINES – REACH OUT

Staffordshire Access Team – 24/7 Urgent Help: **0808 196 3002**

PAPYRUS PREVENTION OF YOUNG SUICIDE 0800 068 41 41 Helpline papyrus-uk.org	mind 0300 123 3393 Helpline mind.org.uk	SAMARITANS 116 123 Helpline samaritans.org
YOUNGMINDS Text YM to 85258 Text Service youngminds.org.uk	shout 85258 here for you 24/7 Text SHOUT to 85258 Text Service giveusashout.org	THE MIX Text THEMIX to 85258 Text Service themix.org.uk

If I have used my plan and feel that I am at serious risk of harm to myself, I will go to the hospital's accident and emergency department. If I can't get there safely, I will call 999 for help.

Appendix G

Online Safety Information Sheets

Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

STAFFORDSHIRE UNIVERSITY

Online safety information sheet (for parents/guardians)

You can find helpful information about online safety and privacy by going to this YoungMinds web page:

online-safety-updated-feb-2020.pdf (youngminds.org.uk)

Online safety information sheet (for participants aged 14-18)

The photos/artwork you create during this research project are your property. They belong to you. You do not have to share them with anyone outside of the research. If you are thinking about sharing your photos/artwork with others in your social circles, or on social media, it's important to think carefully about how this would make you feel, and whether you are safe to do so.

You can find lots of helpful information about online safety and privacy by going to this ChildLine web page:

https://www.childline.org.uk/info-advice/bullying-abuse-safety/online-mobile-safety/taking-care-your-digital-footprint/

Remember if you're ever unsure about something, you can speak to an adult you trust, like your parent/guardian or your CAMHS keyworker.

Appendix H

Photo-task instruction sheet

Adolescent meaning-making of self-compassion during mental distress

Thank you so much for taking part in this project! You have 2 weeks to take photos/create artwork, from the day you are given these instructions from Charlotte.

Please take photos of

1) what self-compassion means to you,
2) and things you experience in your life about being self-compassionate.

This could be messages from other people, social media, or anything else that feel important to you around self-compassion.

Don't forget! Photos must not include other people's faces. You can draw the situation instead if you would like to. You can text or call me on *07890054848* to ask any questions.

Please bring your camera and/or artwork to the interview. Email me a copy of the photos beforehand if you can. My email is c043215m@student.staffs.ac.uk. If you can't email them, we can organise an interview in person and look at them together on your camera during the interview.

All done? I'll look forward to hearing all about it at your interview!

Appendix I

Study Interview Topic Guide

- ***Ask whether participant is comfortable to share their demographic information – see Demographic information sheet for demographic questions***
- ***Give the participant five minutes familiarising with photos and choosing 3-6 key photos [emphasising there are no right or wrong answers.]***

[Questions to be asked per photograph/artwork piece]

1. Can you describe to me what is happening in this photograph/piece of art *probe: or* what this photo means to you? Probe: what made you take this photo? Where was the photo taken?
2. How does this photo/ piece of art help you to explain what self-compassion means to you? (It is okay if you are not sure. There is no right or wrong answer.)
3. How were you feeling at the time of taking this photo/ piece of art? Probe: do you feel any emotions or physical sensations now in response to this photo/ piece of art?
4. Can you describe to me what it is about this photo/ piece of art that connects with self-compassion for you?
5. If you were using this photo/ piece of art to describe self-compassion to an alien, what would you say? [it's okay if you're not sure]
6. What do you imagine other people might say to you about this? What would someone who is important to you say about this? Probe: family, friends, teachers, CAMHS workers [it's okay if you're not sure]

7. What does this photo/ piece of art say about what others around you were doing that was self-compassionate? Probes: What does this photo/ piece of art tell you about your friend / family's experiences of self-compassion? [it's okay if you're not sure]

   [Closing questions after reviewing all 3-6 photos]

8. Are there situations when you find it easier or more difficult to experience self-compassion?
9. What, if anything, did you notice whilst you were doing this task about what others around you were doing or saying about being self-compassionate? Probe for behaviours, communications
10. Overall, what, if anything, have you learnt about self-compassion by doing this task? [There are no right or wrong answers, you might not have learnt anything] Probes: What, if anything, is important to you about self-compassion?

Appendix J

Voluntary Demographic Information Sheet

About You This questionnaire asks some general information about you, such as your age, nationality, ethnicity etc. You can preference not to say.	
How do you describe your gender identity?	
What is your age?	
What is your nationality?	
How would you describe your ethnicity:	Probe: Which of the options [on this card/below] best describes your ethnicity? White 1. White – British 2. White – Irish 3. Any other white background Mixed: 4. Mixed - White and Black Caribbean 5. Mixed - White and Black African 6. Mixed - White and Asian

	7. Any other mixed background 8. Arab Asian or Asian British: 9. Asian or Asian British – Indian 10. Asian or Asian British – Pakistani 11. Asian or Asian British – Bangladeshi 12. Any other Asian/Asian British background Black or Black British: 13. Black or Black British – Caribbean 14. Black or Black British – African 15. Any other Black/Black British background Chinese or another ethnic group: 16. Chinese 17. Any other (please describe)
How would you describe your sexual orientation	Probe: Which of the options [on this card/below] best describes how you think of yourself? 1.Heterosexual or Straight 2. Gay or Lesbian

	3. Bisexual 4. Other 5. Prefer not to say

Appendix K

Participant information sheet (adolescents)

What does self-compassion

Are you aged 14-18 and receiving support from a CAMHS keyworker? We're interested in hearing about your experiences of self-compassion.

Lead Researcher:

My name is Charlotte Cochrane. I love dance, yoga and cooking.

I'm training as a clinical psychologist and

I work for Midlands Partnership University NHS Foundation Trust.

I'm doing a research project as part of my training in Clinical Psychology with Staffordshire University, which you could take part in.

Figure 1 Lead Researcher's Emoji

You can watch a short introductory video about the project by clicking this link: A3FF9A84-8346-46B4-A942-F5B34C640C0F.MOV

Before you decide whether you want to take part, it is important to understand why I'm doing the research and what I would ask you to do.

Please take time to read the info below very carefully and talk to someone that you trust to help you decide whether to take part.

Please ask me if you have any questions about it, I'm happy to help 😊

Are you under 16 years old?

If yes, your parent or guardian also need to agree to you taking part in the research.

Why am I doing this research?

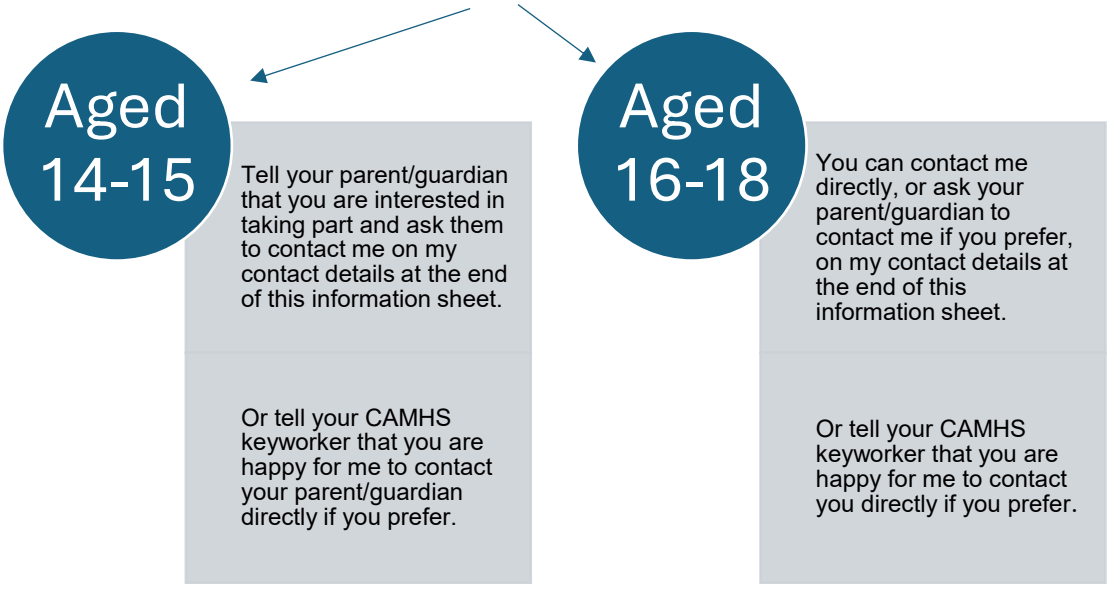
Research so far has said people aged 14-18 can feel self-critical and have low self-compassion levels.

I want to learn about your experiences of what self compassion is. There are no right or wrong answers. I am trying to understand what you learn about self-compassion from the experiences that you have.

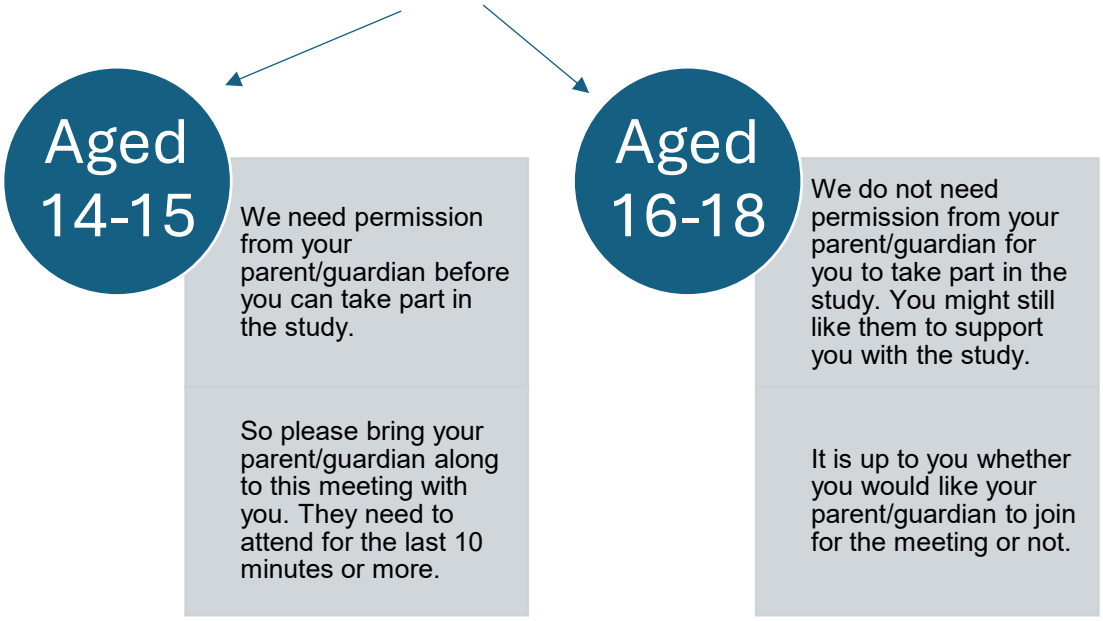
I hope to share key themes about adolescent experiences of self-compassion with children's mental health services, so that they can learn more about the support adolescents might need.

How do I take part and what happens next?

Please let me know you are interested in taking part in the study. You can still say you do not want to take part at any time without giving a reason, but



The next step is to arrange a time to meet so that I can tell you more about what the study would involve for you. We can meet either in your home, on Microsoft Teams or at one of our child and adolescent mental health services. We



Take some time to think about whether you want to take part – it might help to talk to someone you trust about it

If you still want to take part after hearing more about the study at our first meeting, let me know and I will ask you to sign a form which shows that you are happy to take part. You can send me your form via post or email, or I can collect the form in person. I will also sign the form and give you a copy (either via email or when I next see you).

If I have not heard from you or your parent/guardian I will re-

Aged 14-15

Both you and your parent/guardian will need to sign a form if you are both happy for you to take part in the study.

So make sure you ask them to get back in contact with me if you want to take part or have any other questions.

Aged 16 -18

We only need your signature if you are happy to take part in the study.

Feel free to get in contact with me if you have any questions still.

After we have all signed your form to confirm you want to take part, I will arrange a time to meet with you to give you instructions about what I will ask you to do.

You will have two weeks to take photos using your camera of anything that helps you to describe and make sense of self-compassion.

You can ask family or friends for help with the task if you want to.

I cannot tell you what I think self-compassion means, because I

You'll then have two weeks to take photos or create artwork about self-compassion using inspiration from things you see, hear, or do!

You will need to use either your own camera or borrow a camera from

I will then invite you to a research interview. This is a conversation about your photos or artwork. I want to try and learn more about your experiences in this conversation. The interview will last 30-60 minutes.

I will ask you to email a copy of your photos or artwork to me or bring them with you to the interview (you can keep photos on your camera, you don't have to print them). I will ask you to choose 1-6 photos or pieces of

What else do I need to know?

Altogether the research would take a maximum of 2 hours and 20 minutes of your time, as well as two weeks of photographing/artwork.

If you would like to check that the key themes I have found in your interview match what you said, this would take another 20 minutes of your time.

The interview will be recorded using Microsoft Teams (Microsoft Teams will also type our conversation so that I have a copy to read). I will listen to the audio of the interview recording and check that the written copy of the conversation is correct. I will keep all information about you safe and secure. No-one will be able to tell who you are from your photos, artwork, interview recordings or written copy of the interview. I will change your name to a different name when I check the written copy. The recording will be permanently deleted as soon as I have the completed written copy of the interview. All the information I have will be stored on Staffordshire University OneDrive and will only be accessed by me. I will keep personal data (names and addresses etc.) very secure.

Do I have to take part?

No – it is completely up to you 😊

Your decision to take part in this project or not, will not affect your mental health support from mental health teams.

What if I change my mind?

You can stop taking part in the research project at any time, without giving a reason.

You can stop taking part by telling me, the researcher, that you do not want to take part anymore. You do not have to give me a reason. You can tell me in person, via telephone or email, or ask your parent/guardian to tell me on your behalf.

After you have completed your interview, you will have up to seven days to tell me you do not want your interview data to be a part of the research. After seven days, data analysis will have started, and it will be impossible to remove the information you provided.

If you stop taking part in the research, we will keep your agreement/ consent form as a record and add the date you decided to stop taking part to the form.

You have the choice if you would like to be contacted after the research interview to provide feedback on the research project or receive a summary of the research report itself. You can select either opt in or opt out on your agreement form to indicate your choice.

Are there any risks of taking part?

I have a responsibility to pass on any information to the relevant person if I'm worried about risk of harm to you or a vulnerable adult or child. If you tell me something I am worried about, like a risk to yourself or others, I will talk to my supervisor about it, and I may need to share this information with your parents/guardians and your keyworker in your mental health team.

You might talk about something upsetting when I ask you about your experiences. I will explore how you are feeling throughout the interview. I will also give you and your family a signposting leaflet, telling you about mental health support in your local area. I can also tell your key worker about anything that upset you in the interview if you want me to. If I am worried about your safety, I will have to tell someone in your mental health team who can help you.

I will talk to you first about all of the options so that we can work together to decide how best to support you.

What if someone else sees my photos?

The photos will be on your phone/camera. You don't have to show your photos/ artwork to anyone other than me. Photographs and artwork will only be shared outside of the research team with your permission. They would be shared to help explain the research findings to other researchers and mental health workers. Photos would only be shared if there are no people in the photo.

What's positive about taking part?

It could be an opportunity to explore self-compassion and express yourself. I can't be sure that you will find the process positive, as you may find talking about some things upsetting. The research is not an opportunity for therapy.

Where does my information go?

I will need to use information from you, and your parent/guardian if you're aged 14-15, for this research project. This information (also called, data) will be processed under the

General Data Protection Regulation 2016 (GDPR). You can watch a video explaining GDPR here: https://www.youtube.com/watch?v=VlI6V1MgZgY

You can find out more about how your information is used at https://www.hra.nhs.uk/information-about-patients/.

I will store your data for this study because the study aims to help the general public: it is a 'task in the public interest'.

This data will include your name, initials, preferred contact details, and home address (if you would like me to meet you at your home for the study meetings). It will also include your consent to contact your parent/guardian about practical arrangements of study meetings, and extra demographic information you give to me at your interview (gender identity, nationality, ethnicity, sexual orientation). You can refuse to answer questions about this extra demographic information, you do not have to tell me this personal information if you do not wish to. I will ask you for this information to help me reflect on how these aspects of your identity link to the experiences you talk about in your interview.

People who do not need to know who you are will not be able to see your name or contact details. Your name will have a code number instead.

We will keep all information about you safe and secure. The information will be stored on a password protected Excel sheet.

Staffordshire University is the sponsor organisation and data controller for this study. Photos, artwork, interview recordings and all other study data will be securely stored on Staffordshire University OneDrive and will only be accessed by myself, as the chief researcher.

I will separate personal identifiable data (names and addresses etc.) from all other data. Interview transcripts will be anonymised; I will give you a different name in the reports and all identifiable information will be changed or removed.

Once we have finished the study after the final participant meeting, I will keep some of the data so I can complete analysis and check the results against the data. Data will be kept on the University OneDrive for the shortest time possible. I aim to complete analysis within three months.

I will write the reports in a way that no-one can work out that your child took part in the study. Data will only be shared within the research team. It will not be shared with any third parties. Research supervisors will be shown anonymous excerpts from the transcripts and themes discussed to strengthen the trustworthiness of the analysis. Personal data, including consent forms, will be stored for 3-6 months after the study has ended. Anonymous data will be kept for 10 years following project completion and stored in a secure archive room in Staffordshire University; and thereafter destroyed.

You have choices about how your information is used:

- You can provide your consent for the use of your personal data in this study by completing the consent or assent form that has been provided to you.
- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

- Questions, comments and requests about your personal data can be sent to the Staffordshire University Data Protection Officer. If you want to make a complaint with the Information Commissioner's Office, please visit www.ico.org.uk

Where can you find out more about how your information is used?

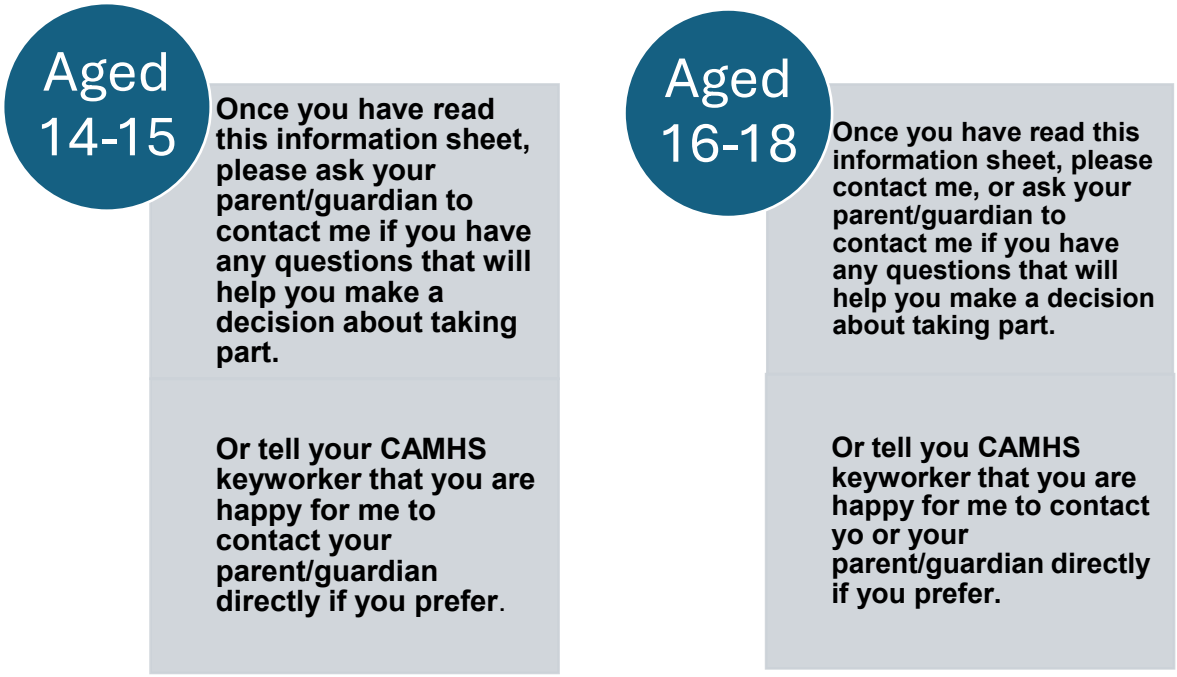
- You can find out more about how we use your information at: www.hra.nhs.uk/information-about-patients/
- Or by sending an email to Staffordshire University data protection officer at: dataprotection@staffs.ac.uk

What does this mean you do with the info I tell you during the study?

- Nobody will be able to tell who you are. I will change all names and personal information. I will pick out key themes about what you and others have said. You will have an opportunity to check whether you agree with the key themes I pick out from your interview.
- You will be asked whether you would like to choose 1-3 photographs for me to use as examples to share the key themes with others. Only photos where nobody is recognisable can be chosen. And you don't have to choose any.

- I will write an essay for my training course, writing about how what you told me can help inform mental health services and psychologist's work. I aim to publish my writing in a research journal too.

- I will aim to find spaces to share your thoughts about what self-compassion means for adolescents e.g., on a poster in mental health teams' waiting rooms. The findings will also be written into summaries for you and your families. I can send you a copy of this if you'd like one! 😊



Thank you for taking the time to read this info sheet.

If you want to take part or ask me for more information, please contact me by phoning or texting my work mobile number:

Work Mobile: 07890054848

or emailing me at:

Email: c.cochrane@student.staffs.ac.uk

I can not always reply immediately – I will respond to contacts as soon as I can. I am only contactable for the purpose of this research. If you need mental health support, please contact your CAMHS team.

Investigator: Charlotte Cochrane,

Science Centre, Leek Rd, Staffordshire University

Appendix L

Parent/guardian Information Sheet

INFORMATION SHEET FOR PARENTS/GUARDIANS OF PARTICIPANTS

NHS Midlands Partnership NHS Foundation Trust A Keele University Teaching Trust

Project Reference Number: [insert once provided by the university ethics committee]

STAFFORDSHIRE UNIVERSITY

Older adolescent meaning-making of self-compassion during mental distress

How do older adolescents experiencing mental distress make sense of the concept of self-compassion? Exploring socio-cultural influences through a photo elicitation and interpretative phenomenological analysis study.

Invitation Paragraph

I would like to invite your child to participate in this research project which forms part of my Doctorate in Clinical Psychology research. Before they decide whether they want to take part, it is important for them to understand why the research is being done and what their participation will involve. Please take time to read the following information carefully and discuss it with your child. Please feel free to ask me if there is anything that is not clear or that you would like more information on.

What is the purpose of the study?

I would like to explore the older adolescent perspective of self-compassion. I am aiming to explore the perspective of 14-18 year olds, who are accessing child and adolescent mental health services (CAMHS). In doing so, I am aiming to better understand social and cultural experiences of self-compassion as experienced by older adolescents. The project aims to inform therapeutic interventions around self-compassion and to widen clinicians' understanding of what self-compassion means to older adolescents.

Research to date has suggested that adolescents aged 14-18 tend to have lower self-compassion than younger adolescents. I would like to explore experiences of self-compassion with older adolescents who experience mental distress, with a view to informing future interventions and therapeutic approaches intended to promote self-compassion.

Why has my child been invited to take part?

Your child has been invited to take part because they have been identified as being between 14-18 years old and are allocated a keyworker for mental health support within CAMHS.

What will happen if we take part?

Your child will be invited to take part in a research task whereby I will ask them to take photos or create artwork of things that help them to describe their day-to-day experiences of self-compassion. Participants will be asked to spend two weeks completing this task. They will need to take a minimum of one photo or create one piece of artwork. I will ask for photos/artwork to be emailed to me where possible or alternatively brought with them to their in-person interview on their digital camera.

Please note that unfortunately, the project is unfunded and digital cameras for your child to use will need to be provided by yourself. They can draw/create artwork instead of taking photos. If you do have a digital camera that your child can use which is on your mobile, this might also result in increased screen time for the two-week period of the study task.

I will invite participants to a research interview which is expected to last no longer than 60 minutes. In the interview, I will ask the participants to choose their favourite 3-6 photos. I will ask the participants questions about their photos such as 'can you tell me more about this photo?' 'What was happening at the time?' 'How did you feel at the time?'

Interviews can take place via MS Teams, at your home address, or at one of our CAMHS bases; whichever you and your child are most comfortable with. Both in person and online interviews will be audio-recorded using MS Teams (which will also facilitate reliable transcription) on Staffordshire University OneDrive. . I will listen to the audio of the MS Teams recording and check that the written transcript is correct. At this point I will anonymise the written transcript, by changing or removing any identifiable information and using a pseudonym in place of all names. The MS Teams recording will be permanently deleted as soon as I have completed the written transcript.

How much of our time will it take?

If your child is 14-15 years old, they need your parental consent before they can take part in the study. You would therefore need to be present at the first two meetings whilst getting to know myself, as the researcher, and what the study involves. It is up to your child whether they want you to accompany them into their research interview. If your child is 16 years or

older, they are old enough to independently consent to taking part in the study unless the researcher has concerns otherwise.

I will offer to meet with you two-three times before your child starts the study (see table below).

Meeting	**Time and location**
Initial meeting to get to know each other and answer any questions.	30 minutes at a time and place convenient to you (Microsoft Teams, Mental Health team base, or in your own home)
Second telephone call/email or MS Teams or in person meeting to check you and your child are fully informed about the project and ask for signed consent.	20 minutes at a time and place convenient to you (Telephone, email, Microsoft Teams, Mental Health team base, or in your own home)
Meeting to give you and your child a set of instructions and plan the next steps and photograph or artwork collection.	30 minutes at a time and place convenient to you (Microsoft Teams, Mental Health team base, or in your own home)

Your child will be asked to take photos or create artwork within a two-week period. The amount of time spent taking photographs/ creating artwork within these two weeks is optional; provided they take at least one photo or create at least one piece of artwork over the two weeks. For the study your child will be asked to take a maximum of one photo or

produce a maximum of one piece of artwork a day so that they do not have too many to choose from in their interview.

If your child is meeting with me for a research interview on Microsoft Teams, they will need to email me their photos/ a picture of their artwork. This is expected to take 15 minutes of your time.

Your child's interview is expected to last between 30-60 minutes. Altogether this would take a maximum of 2 hours and 20 minutes of your time, excluding the two weeks of photographing/artwork.

If your child wants to check the key themes I have found in their interview, this would take another 20 minutes. This does not account for travel time to meetings. Where preferable, I can meet with you at your home or on a Microsoft Teams call.

How will information about us be used?

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR). The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest'. You can find out more about how your information is used at https://www.hra.nhs.uk/information-about-patients/.

We will need to use information from you and your child for this research project. This information will include your name, initials, preferred contact details, and home address (if you request home visits for the study meetings). It will also include your child's name,

initials, age, preferred contact details, consent to contact parent/guardian about practical arrangements of study meetings, additional demographic information given at interview (gender identity, nationality, ethnicity, sexual orientation). All participants will be reminded of their rights to refuse to answer questions about demographic information.

People who do not need to know who you and your child are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure. The information will be stored on a password protected Excel sheet.

Staffordshire University is the sponsor organisation and data controller for this study. Photos, artwork, interview recordings and all other study data will be securely stored on Staffordshire University OneDrive and will only be accessed by myself, as the chief researcher. I will separate personal identifiable data (names and addresses etc.) from all other data. Interview transcripts will be anonymised; I will give participants pseudonyms and all identifiable information will be changed or removed.

Once we have finished the study after the final participant meeting, I will keep some of the data so I can complete analysis and check the results against the data. Data will be kept on the University OneDrive for the shortest time possible. I aim to complete analysis within three months.

I will write the reports in a way that no-one can work out that your child took part in the study. Data will only be shared within the research team. It will not be shared with any third parties. Research supervisors will be shown anonymous excerpts from the transcripts and themes discussed to strengthen the trustworthiness of the analysis. Personal data, including consent forms, will be stored for 3-6 months after the study has ended. Anonymous

data will be kept for 10 years following project completion and stored in a secure archive room in Staffordshire University; and thereafter destroyed.

What are my choices about how our information is used?

- You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.
- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.
- Questions, comments and requests about your personal data can be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk

Where can I find out more about how our information is used?

You can find out more about how we use your information at:
www.hra.nhs.uk/information-about-patients/

Or by sending an email to Staffordshire University data protection officer at:
dataprotection@staffs.ac.uk

Does my child have to take part?

Participation is completely voluntary. Your child should only take part if they want to and choosing not to take part **will not** disadvantage them and their care, which they receive from NHS services, in any way. Once you and your child have read the information sheet,

please contact me if you have any questions that will help you decide about taking part. If you decide to take part, I will ask you to sign a consent form and you will be given a copy of this consent form to keep.

Your child can withdraw from the research project up to 7 days after their interview, without giving a reason. After 7 days, data analysis will have started, and participant data will be anonymised and combined with other data and can no longer be withdrawn. The researcher will also remind you of this before the start of the interview.

You have the choice if you would like to be contacted after the research project is completed, to provide feedback on the research project, or receive a summary of the research report itself. You can select either opt in or opt out on the consent form to indicate your choice.

What are the possible risks of taking part?

The research is focused on a positive emotion, self-compassion, and therefore it is not anticipated that interviews will result in distress for your family. However, there is always risk of distress when exploring individual experiences in research interviews, and it may be that if barriers to self-compassion are addressed, this could increase distress for your child.

As the researcher, I will offer your child the opportunity to check in with how they are feeling throughout the interview. I will give each family a signposting leaflet, informing you of mental health support in the local area. I will also inform the child's key worker in CAMHS about any concerns that arose during the interview if your child consents for me to do so.

I have a responsibility to pass on any information to the relevant person if I am worried about risk of harm to participants or a vulnerable adult or child. If your child discloses information of concern such as risk to self or others, I will discuss this with my

supervisor, and may need to share this information with yourself and your child's keyworker in their mental health service to support keeping the vulnerable persons safe. I may have a duty to pass on information to the relevant agency or person to safeguard the child or vulnerable person.

As mentioned, digital photographs may consequently increase the amount of time your child is spending on a mobile, tablet or other digital device. This could also increase their access to online content where mobiles are included. An online safety leaflet will be offered to each participant. The researcher will also clearly explain matters of privacy when giving the photo task instructions to children. Participants will be asked not to take photos of other people.

Photographs will only be shared outside of the research team with parental/guardian and child permission, for the purposes of dissemination of the research findings (for example, in my thesis report and presentations). Participants will be asked if they consent for me to share 1-3 of their photos for the purpose of disseminating the research findings. Photos would only be shared with participant permission and if there are no people present in the photo (to prevent risk of them being identified).

What are the possible benefits of taking part for my child?

The research could provide an opportunity for the participants to explore the protective emotion of self-compassion. The project might also give participants an opportunity to express themselves creatively. However, the researcher does not know what the participants will bring in answer to the questions within the project, and there is no intended direct benefit for the child; the research project is not a therapeutic intervention.

What if we change our minds about taking part?

You and your child are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect your child's care from mental health services in any way. If your child wishes to withdraw from the study at any point, they need to simply inform the research team. If they wish to withdraw their data after they have participated in their interview, they will have up to seven days to do so after which time, data analysis would have commenced, and it will be impossible to withdraw any information provided. If participants withdraw we will keep their consent form as a record, with date of withdrawal added to the form.

Your child can stop taking part in the study by telling me, the researcher, that they do not want to take part anymore. They do not have to give me a reason. You or your child can tell me in person, via telephone or email (using my contact details at the end of this information sheet).

What will happen to the results of the study?

Photographs or artwork will only be shared outside of the research team for the purpose of sharing the findings if you and your child give your consent to do so and if no people are in the photographs. Participants will be asked whether they are willing to choose one to three photographs for the researcher to use in dissemination of the findings. Only anonymised photographs would be included as an option (e.g., of inanimate objects).

Anonymised findings will be shared in the form of a thesis for the purpose of the Professional Doctorate in Clinical Psychology. I aim to publish the thesis in a relevant academic journal and to also disseminate the findings to CAMHS teams. The findings will also be written into executive summaries which are accessible to the adolescent age group

and a lay adult. The findings will be posted or emailed to the families who took part in the study, given your consent to do so.

Who should I contact for further information?

If you require more information about this study or would like to take part, please contact me using the following contact details:

Principal Investigator: Charlotte Cochrane

Science Centre, Leek Rd, Staffordshire University

Email: C.Cochrane@student.staffs.ac.uk

Mobile: 07890054848

Chief Investigator: Dr Nicholas Davies

Science Centre, Leek Rd, Staffordshire University

Email: nicholas.davies@staffs.ac.uk

You can also talk to your key worker in CAMHS and ask them to inform me of your interest to take part, and of your consent for me to contact you directly.

What if I have further questions, or if something goes wrong?

If this study has harmed, you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Professor Sarahjane Jones

Sarahjane.jones@staffs.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix M

Parent/guardian consent form

Consent form (to be completed by parent/guardian of participants aged 14-15 years old)

<u>Parent/guardian consent form: older adolescent meaning making of self-compassion</u>

Please put your initials in the box next to each statement if you consent to the statement. Participants aged 14-15 must have parental/guardian consent to take part in the study.

	Study ID number:	**Parent/guardian initials:**
	I confirm that I have read the attached information sheet (**Version XX, Date dd/mm/yyyy**) for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
	I understand that my child's participation in the study is voluntary and they are free to withdraw at any time without giving a reason and without detriment to themselves.	
	I understand that it will not be possible to remove my child's data from the project once it has been anonymised and forms part of the data set.	

	I agree to my child's interview being audio recorded for the purpose of data transcription.	
	I agree that any data collected may be published in anonymous form in academic books, reports or journals.	
	I agree to my child taking part in this study.	

I would like my child and I to be contacted about the findings after the research is comple☐. Please cl☐k:

Participants Name ---------- Signature ---------- Date ----------

Parent/
guardian's Name ---------- Signature ---------- Date ----------

Chief
Researcher's Name ---------- Signature ---------- Date ----------

Opt in Opt out

Appendix N

Adolescent participant assent form (aged 14-15 years)

ASSENT FORM (to be completed by participants aged 14-15 years)

Assent form: older adolescent meaning making of self-compassion

Adolescent (or if unable, parent on their behalf) to circle all they agree with:

Do you understand what this project is about? **Yes/No**

Have you asked all the questions you want? **Yes/No**

Have you had your questions answered in a way you understand? **Yes/No**

Do you agree to your interview being audio recorded for the purpose of data transcription? **Yes/No**

Do you agree that any data collected may be published in anonymous form in academic books, reports or journals. **Yes/No**

Do you understand that taking part in this project is voluntary and you are free to withdraw at anytime? **Yes/No**

Do you understand that it will not be possible to remove your data from the project once it has been anonymised and forms part of the data set? **Yes/No**

Are you happy to take part? **Yes/No**

Would you like to be sent a copy of the findings once the project is completed? **Yes/No**

If any answers are ‘no’ or you don’t want to take part, don’t sign your name!

If you do want to take part, you can write your name below.

Your name: _____

Date: _____

Researcher’s name: _____

Researcher’s signature: _____

Date: _____

Appendix O

Example of Forming Personal Experiential Statements

Analysis key:

Blue – participant's experiential claims, concerns and understandings (staying close to participant's experience – phenomenological) and phenomenological, interpreted within context of the whole conversation

Purple – researcher's interpretations inspired by participants experiential claims (hermeneutic)

Green - Experiential statements

P1: I think I'm no good at it.

Position of self as incompetent? No good at self-compassion. Something you do? I'm considering the experiences he has had which develops a relational identity as 'no good'. Starting position of 'I think, I am….' – does this reflect the adolescent developmental stage of Identity vs Confusion, ie. who am I? Self-compassion as another thing to try and be good at.

I: What is it that you're thinking of that you don't feel good at?

P1: I'm just not self-compassionate.

Certainty that he's not self-compassionate. Sadness, feeling that he does not like himself or want to be compassionate to himself? A rejection of self-compassion? 'I'm just not' – an absolute, simplicity – blocking wider conversation / thought about it. Is this in direct contrast to the context of the conversation where he is positioning himself as incompetent / no good? Or experiencing negative thoughts or feelings about himself? Dichotomous thinking? Talking about an abstract concept in concretes? (Systemic literature re. reifying constructs). Is society talking about self-compassion as something you are or are not? Rather than fluid, performed, relational and distributed? (Coombs & Freedman, 2016)

Self-compassion at something that you do or are rather than fluid/performed/relational/distributed

I: So what does it look like if you were self-compassionate? What do you think you should or could be doing if you were more self-compassionate?

P1: Just like, you know more stuff, like I just sit on my arse with my dog and that's it.

*Experience of needing to do things to act self-compassionately. What 'stuff' is more self-compassionate? And uncertainty about what to do? **R**epetition of the word 'just' – opposed to being more, doing more. Is there a lack of access to self-compassion and a not-knowing about what stuff to do?*

Appendix P

Member Check Notes

Participant	Experiential statement	Member check notes
Noah	- A sense that bad things can happen at any point, and self-compassion is about finding moments to self - Can understand what led to a bully's behaviour but can't forgive himself for acting out of his own anger because it hurts people. - Learnt from his mum that taking care of others is an act of kindness to oneself.	- Emphasis on relaxing and feeling 'off guard' - Can understand other people but forgiveness is a different story. - Mum didn't have a childhood herself; she gave up her life to raise the others. 'Putting up with other people' and act of kindness to others. It's a balance to prioritise your own needs alongside tolerating others who haven't been nice.
Amy	- Animals 'sit alongside' your suffering, non-judgementally unlike peers - Reading fiction is a chance to experience / connect	- Peers don't know how to talk to each other - Fiction characters help you see the possibility that other people might feel that way too.

	with characters who've had similar experiences	
Amber	- 'Put on medication' – a sense of 'done to' / disempowerment / needing someone else to care for you when you're burnt out? - Finding comfort in familiar routines and spaces.	- Accepting medication felt like my friends who bullied me had won, it felt like a defeat to give in to medication. stopped doing activities and rested when accepted the meds, meds helped her tune into struggles and accept help. Also experienced a phobia of swallowing tablets. Now she reminds herself that the medication isn't forever, and only whilst she needs it. - Wanting to keep safe spaces as safe spaces e.g. Not sleeping in own room when burnt out.
Sienna	- It's rare and special to find someone who understands you	- Compassion is because of everything else, other things than just

	- Finding ways to heal yourself: the importance of childhood joy/playfulness/innocence - Self-affirmations to take care of yourself e.g. everything will be okay - Self-compassion is about finding happiness. - The importance of ACTS of kindness: when words are less meaningful - It takes time and patience to build safe space to talk with others	understanding e.g. acts of kindness feel important. - The innocence before everything happened with Grand-dad - If you don't then you're not going to feel compassion, got to be kind to yourself. Negative feelings bring you down and make it harder to feel compassion. - If you don't have happiness you're not able to give or feel compassion. - It can be little things e.g. they'll remember things you've told them. - when people rush you it puts you off. Being patient shows they want to sit with you and be with you.

		-
Betty	- Small acts of kindness, like giving a compliment, can make a significant difference.	- Small acts of kindness are more important than compliments.

Appendix Q

Example Table of Personal Experiential Themes

Table of Personal Experiential Themes (PETS) [Participant 1].
A. Self-compassion depends on liking yourself and being liked by others.
Undeserving of self-compassion, if there's nothing you like about yourself *Feeling undeserving of self-compassion,* unless there is something to like about oneself. P.14 *'It's about being kind to yourself. But I'm not kind to myself because I don't deserve to be... No, because I think I'm shit.'* *Can't be self-compassionate about things he views as negative about himself. P.27* *'I: Do you think having a diagnosis of ASD affects your experiences of self-compassion? P1: Well yeah because it's just not a good thing, I feel embarrassed about it, you know.'* *Self-compassion as another thing to feel self-critical about if struggling to be self-compassionate. P.15* *'Yeah cause it's like a negative thing because I'm not self-compassionate.'*

Not being accepted by others

A need for others to like him before he can like himself. P.11.

'Yeah cause I just never really like, no-one has ever really like, liked me really.'

Can't be kind to oneself when feeling othered and disliked. P. 31

'Awful, because I've got nothing to be kind to myself, I'm not good at anything. I'm different. I'm weird. No-one likes me. What can I be positive about?'

B. Self-compassion is active: people say you should find motivation to take care of your mental health and achieve things.

Self-compassion is about loving yourself through task focused actions. P.4.

'It's about loving yourself, waking up and doing everything, I don't really do anything...'

Messages around 'do great and control your mind' – whatever you are feeling, mind over matter, stay focused on the task/goal. P.5.

*'You see people just, like 'wake up and do your routine and do great and control your mind'. I'm like, come on. How have people got the time for this, to p*** about all morning. Doing all that s*** and putting like 100 things on their face, and having a run like come on.'*

Self-compassion perceived as taking care of oneself, but you need the motivation to do that. P. 6.

*'Well it's just caring about yourself innit, because I, like, my skin is in ***t shape because I don't put loads of stuff on it. But you know, I just can't be arsed and that's my choice. Like people run to be healthy and I'm like, that's fair enough, but I can't be arsed. But I'd probably be happier, but I can't be arsed to do anything.'*

C. People focus on self-love to alleviate suffering, which seems pretentious / arrogant.

Self-compassion as task focused, which is a pretentious thing. P.5

'It's something that pretentious people say, you need to love yourself and wake up in the morning and do star jumps and stuff.'

Saying 'I love myself' suggests you love yourself too much / you are arrogant. P.4.

'Sometimes I think it's a bit up your own arse, like, 'I love myself'.'

D. Feeling like I should be taking care of myself and achieving things, but I have no motivation

Self-compassion as something that should be simple, by knowing what you like and taking care of your physical and mental health, but it's difficult to do. P.22.

'I dunno just try do things that are good for your health like eat right, and run and try not to worry. I can't figure that out but.'

Doing something/ knowing how to alleviate your own suffering as a self-compassionate experience, but needing motivation to achieve that. P.15

'I just haven't got the energy and I'm just sitting in my bed'

Other people trying to encourage him to move from threat mode to drive mode, but are missing experiences in soothe mode. P.7

'Well yeah I guess, they're just trying to make you feel better. I probably would feel better if I put, like did all that, but I just don't want to.'

It's a lot to ask to move between threat and drive mode without any motivation, need more time in soothe mode. P.6.

'I don't have the motivation to do anything so that would be quite a lot.'

Self-compassion at something that you do or are rather than a fluid experience P. 3.

'I'm just not self-compassionate.... I: So what does it look like if you were self-compassionate? What do you think you should or could be doing if you were more self-compassionate? P1: Just like, you know more stuff, like I just sit on my arse with my dog and that's it.'

E. It helps when people listen to negative experiences, rather than trying to change them

Kinder to acknowledge the negative experiences

It feels delusional to not acknowledge the negatives when can't find any self-positives. P. 11.

'Yeah well it's kinder than just being delusional, and saying that everything's great when it's not.'

When people ask you to find the positives it feels like they don't want to listen to the negative experiences. P.13.

'No, so he preaches all this about being positive and he's not. He just doesn't want to listen to me be negative, so he just tries to pacify me and shut me up pretty much, is how it feels.'

Self-compassion requires you to deal with the negative experiences to make yourself feel better. P.33.

'Yeah, it's just kind of, cause I can't just deal with it.'

Difficult to stay with the negative experience, need distraction

Using music to forget negative experiences when not feeling self-compassion. P. 32.

'Play some music or guitar... I just forget for a few minutes'

Compassionate witnessing

Experiences compassionate witnessing with CAMHS keyworker. P.30.

'Yeah, I tell [keyworker] most things.'

His dog offers an experience of someone sitting with him and staying with his sadness alongside him. P.20.

'Yeah he'll come onto the bed and he just sits there.'

Appendix R

Example of Cross-Case Analysis to Form GETS

Key:

(Messages to) Love yourself
Non-judgemental spaces
(*Social connection)* … Cultivating compassion through feeling understood by others / Sharing laughter/playfulness
(Self compassion as resistance?) Self-expression / seeking individuality / resisting conformity or authority
(*The opposite experiences to compassion)* School systems and bullying
(Productivity culture? / curated versions of self care?) Take care of yourself

Participant	PETS and PET subthemes							
								263
Tommy	*Self-compassion depends on liking yourself and being liked by others.* ***Undeserving of self-compassion, if there's nothing you like***	*Learning from others to take care of yourself and focus on achievements, but I'm not motivated to do that.*	*People focus on self-love to alleviate suffering, which seems pretentious / arrogant.*	*Feeling like I should be taking care of myself and achieving things, but I have no motivation*	*It helps when people listen to negative experiences, rather than trying to change them* ***Kinder to acknowledge the negative experiences***	*Self-compassion is active: people say you should find motivation to take care of your mental health and achieve things.*	*The impact of bullying and feeling othered: 'I don't think I've been kind to myself since I was little'*	

	about yourself ***Not being accepted by others***				***Experiencing compassionate witnessing***				
Noah	*Protecting family: Finding a balance between helping*	*Seeking Safety in Unspoken Spaces: when non-judgmental*	*Turning away from Suffering: by Embracing Playfulness*	*Who can pull me out of spiralling in self-condemnation? Stepping*	*Unattainable self-compassion: the paradox of self-worth*	*De-shaming through relatable stories, and a struggle for*	*Anchoring in Innocence: coping when*	*Self-compassion reliant on self-love*	

	others and focusing on my own needs	*presence matters more than words.* ***Seeking calming and containing environments***	*and Pursuing Success*	*up as a protector of others in seeking redemption.*	*that must be proven.*	*individual understanding*	*safety is so uncertain*		
Amy	*Balancing perspective-taking and*	*Sharing suffering feels intense: a*	*Being led by others: permission*	*Needing social spaces without*	*The invisibility of compassion; systems are*	*Covertly seeking shared experiences*	*Be active: social expectations to cheer*		

	distancing emotion: coping with an inevitability of bad things happening.	socialised relief in humour	to talk about suffering	social expectations	pursuing achievement	of suffering; social expectations to be upbeat	yourself up		
Amber	Self-care rituals, normed in family and social media	Seeking mutual understanding in safe spaces	Accepting burnout; acknowledging struggles	Calming the mind: physical self-care and comforts	Growing patient with my experiences	Balancing putting yourself first and following other people's approach	Finding restorative spaces, without social expectations	Bullying and abuse – escaping harmful environments	Connecting through validation of neurodivergent experiences

Sienna	*Connecting with loved ones*	*Feeling seen and understood by others*	*Learning acts of self-compassion from others*	*Finding social spaces to be yourself*	*Relying on positivity to experience self-compassion*	*Valuing sensitivity and 'being with'*	*Self-care: look after your physical health*		
Elena	*Sharing joy and laughter with loved ones*	*Exchanging compliments; exploring self-expression*	*Finding individuality; resisting social norms*	*Connecting with others through mutual respect*	*Inaccessible compassion: lacking compassion in school environments*	*Finding understanding spaces to accept what is/ yourself as is*	*Escaping your own suffering*	*Finding non-judgemental spaces to just be*	

Betty	*Not expecting acts of kindness* ***Rarity of acts of kindness*** ***The Circularity of acts of kindness***	*Resisting others' judgements, practising self-love and self-expression* ***Love and trust yourself*** ***Expressing yourself***	*Calming through the arts and nature*	*Experiencing acts of kindness* ***Cherishing feeling understood by others***	*Coping with harmful school experiences* ***Too much mainstream attainment pressure*** ***Too much bullying***	*Actively keep yourself healthy*			

		through art and fashion					

Appendix S

Master table of Group Experiential Themes (GETS)

Being Okay with Who You Are

The Conditions for Growing Self Love

Can't be kind to self when feeling othered and disliked

Awful, because I've got nothing to be kind to myself. I'm not good at anything. I'm different. I'm weird. No-one likes me. What can I be positive about? (Tommy, P.31)

Self-compassion is receiving unconditional love: find people you can be yourself around

I mean, it's good to have someone that just loves you for who you can be and who you are. (Sienna, P. 5).

A need for others to like you before you can like yourself.

Yeah cause I just never really like, no-one has ever really like, liked me really. (Tommy, P.11)

Feeling worthless influenced by others' opinions

I: So what inspired you then to paint this?

P7: Erm, self-compassion can go two ways. It can be more like loving yourself.

And also be very negative, you can think very negative, like the thoughts are raining down onto it.

I: yeah. So, this is the negative part down here? With, the colours are kind of like greyer, aren't they? What is it for you about those, that sort of area down at the bottom that feels like the negative bit of self-compassion?

P7: You can think you're worthless and stuff.

I: And is that so these are the thoughts dripping down, did you say?

P7: Yeah.

I: Yeah, when they fall down, they make you feel worthless? Are there sort of specific experiences in your life, that, where those thoughts are more present or louder?

P7: The negative or the positive

I: the negative, sorry.

P7: I think when, it might be a bit random, but when I was in school. And I was in the changing rooms. I'd always think negative on myself, and how I looked.

I: Yeah, that's not random. That makes a lot of sense to me because I think a lot of young people feel that way. A lot of people you know, any age, can feel that way. Can you tell me more about that? Is there anything else that feels important to share about that?

P7: [Pause]

I: You said it was in the changing room and I guess was it the mirrors in the changing room. So does it make you focus in on how you look?

P7: Yeah, compared to everyone else.

I: Yeah. Do people talk about looks much when you were at school. Do people talk about it?

P7: Yeah.

I: Did they say negative things or did they say nice things? Or ?

P7: when I was at school it was quite negative. (Betty)

Self-affirmations: lyrics that heal

Their whole, it's BTF. Their whole like music theme is loving yourself. So they've got like four or five albums about loving yourself. And all the lyrics are about how you can love yourself. And trust yourself. And be…their very good people. (Betty, P.17)

Self-compassion is about loving yourself through task focused actions

It's about loving yourself, waking up and doing everything, I don't really do anything. Just feels a bit like…you know, 'oh I love myself', like, does anyone actually feel like that? (Tommy, P. 4)

Self compassion as external validation: offering and receiving compliments

I think whenever I wear clothes or like nice fashion stuff, that's when I get like my most compliments. (Elena, P.4)

Can't be self-compassionate unless you love yourself entirely

I learned that you can only find it in yourself, if you love yourself, which is very hard to do if you hate yourself more than you love yourself. (Noah, P. 11)

I've learned a lot more, but I'm still struggling, I'm finding, to love myself (Noah, P. 28)

Finding healing through self-acceptance

It just showed me that it's not wrong to, like, have healed like this because I always felt bad for leaving school. But I just think no, you can't feel like that anymore. (Amber, P.18)

No I didn't know what to think. And thinking about it just like the way that I did it was leaving school and just acknowledging that what they did was wrong and I didn't do anything to make them do that, it wasn't my fault… I think it's just, it shows that how people understand themselves. And then healing can use like self compassion and self love to help that, like, help you feel better. (Amber, P.18)

Non-judgmental spaces

Self-blame grew when there was no-one validating his experiences, and then CAMHS helped by being non-judgemental and listening to him.

They just let me talk about what I wanted to talk about. They didn't judge. They didn't say I was selfish. They just listened. (Noah, P.13)

Fear of judgement blocks connection to others, whereas it feels safe to be comforted by his dog who can't judge him.

She can't talk, so she can't judge... I just tell her anything... Even though she doesn't, probably don't want to listen to that [laughs] (Noah, P.31)

Seeking mutual understanding in non-judgemental spaces

Definitely, yeah. You can get comfortable [at home]. Nobody will judge either. Which is good. (Amber, P.35)

Difficult to trust others; finding safe spaces to share experiences

Nobody knew when I was at school, how much it was affecting me. I hid it away, I didn't tell anybody anything. They didn't even know about my autism. I was diagnosed when I was in year 7 and nobody knew, I didn't tell anybody. I didn't trust them. I don't trust many people anymore, either. (Amber, P.24)

Normally I'll never see you again [at CAMHS forest/music group]. These people [at school] I have to see. These people at school, I'd have to see every day for five years. if I tell you here yeah and everything just comes back at you in your school.
Anything can hit you back in the face. (Amber, P.24).

Reciprocal safety when sharing suffering

I think he'd [close friend] say it's [self-compassion] stupid or something. Because we've helped each other out because he's got schizophrenia. So when his, he calls him [voice's name]. So when [voice's name] came back, I was sort of there for him to help him out with all that sort of stuff. And then he would help me out with my sort of stuff. So we can't. We've been there even that's only been six months, there's so much things that I know about him that he's told no one else. (Elena, P.32)

Because like, it's like my friend, all my friends would just talk to me about things, and then they'd be like, oh, I feel really better. And then I'd be like, oh, I need to try that [laughs]. And then it's like very much that like I talk to my mates but then it's like if they're struggling, they'll talk to me. And it's just like that because then it's like no one feels bad about talking because the other person in like 2 months' time or whatever will do the same thing back and then it's just like… (Amy, P. 6)

Social judgement blocks compassion: easiest to be self-compassionate with family who understand.

I mean, my family is very good in understanding. We have very close relationships within my whole family. I think it's good to just know nobody is going to judge you, which

helps with the self-compassion. Then you're like, oh, I can do this without people making fun of it or whatever. If somebody was to say something bad about it, I wouldn't do it. It would be like, well, they've said it's wrong, so I'm not going to do that. (Amber, P.10)

Learning to be patient with oneself – good things take time to grow

Like on this picture it says, 'I'm learning to be patient with myself. Good things take time to grow.' I do like that picture. It's good. (Amber, P.5)

Finding non-judgmental spaces to just be

I think it's just like the atmosphere, because like, it has like it. I can't explain the atmosphere. It's just like, it's a really weird atmosphere. But it's it's not like you're like, there to be judged or like, they're actually there to, like, dissect you. Yeah. You're, you're there because you're there. You're not there to be, like, experimented on or anything like you're you're there to be there. (Elena, P.29)

Non-judgemental spaces

Oh God yeah. I cry with him (pet horse). Yeah, I just sit there [laughing]. What is he really gonna do?... He's not going to judge me. He's not gonna start talking going ' that's embarassing'. Like he might look at me a bit funny, but like. Like, erm, my auntie has loads of like dogs and that so it's quite frequently, like if I'm ever upset with them, they'll just lick my face, which is really disgusting, but, they will lick my face and I go, 'this is really nice guys, but, get off' [laughs]. (Amy, P.16)

Marginalised due to learning difficulties; lack of support from teachers

He would say you should know this. But I have learning difficulties. And Mum told him multiple times. Mum sent emails and emails, even met him in person.

And he just wouldn't listen. And everyone, all the other teachers would stick up for him, saying, oh, it's just the way he was teaching. But his teaching should change for the students. (Betty, P.13)

Saying No to the Way Things Are Normally Done

Resisting the social norms, asserting your own style

I like collected it [jewellery]. And the more I wear, the more I feel comfortable and confident. So, I try and wear a lot. (Betty, p.4)

I like things that make me happy. So I like getting Hello Kitty, and I like pink and like more 2000's fashion and like Japanese fashion as well. (Betty, p.5)

If it's strangers, I don't really care 'cause there not in my life, so I don't care. It can be quite negative if friends and family say something, but I try not to listen to that because they, they aren't me. It's my body. I can wear what I want. (Betty, p.5)

Education harm: there's too much pressure

The pressures, there's too much pressure on teenagers like teenagers brains, they don't, they're still evolving, growing, and there's too much going on for them to for their brain to properly work. And sleep, it's the most important thing for a teenager.But they can't do that a lot because they do 8 hours like 8 hours of school and then they've got after school clubs or something and want to see their friends. And then they've got homework, which I don't think should exist because we already do so much school. And for our brains, that's that's enough. But then we've got homework and we've got, like, shower and stuff. And then we sleep, and then we have to wake up so early. A teenager's brain doesn't start properly functioning until like 10:30. And we have to wake up at like 6:00 AM. (Betty, P.12)

Powerless against authority

It's it's, horrible, honestly, yeah, it's it's horrible. But then in school, you can't say anything because they've got good degrees. Well, sometimes you question that if they've actually got good degrees or not, but… (Elena, P.16)

Erm (resigned sigh) I don't like it. I really don't like it. But I mean, there's nothing you can do because they're like, they're higher than you, basically. And 'cause they're all adults, you can't, you can't say anything. (Elena, p.15)

Finding uniqueness and individuality feels safer than 'fitting in'

There's a difference. Because I used to think, people are looking at me and thinking that looks so stupid in school. But that's because I'm wearing what everyone else wears. And I think that's just something different. But now that I'm standing out in a different piece of clothing, I feel comfortable in it. So it feels nice for people to think, why is she wearing that? Because it's, it's not something everyone would wear every day, so it's not. It's not as much. I mean, yeah, someone might remember it. But it won't be for bad reasons. (Elena , P.7)

Most probably yeah, because I don't speak to them if they say that it's because I'm, I'm just walking and they're just looking and, it's weird, but it's it's just, I don't know, because it's like someone will remember it as being unique and they are going to tell people about it. And it's just, it's different, a different experience, yeah. (Elena, P.8)

Reclaiming self-expression after shaming experiences; taking back control

So now that I get to do it myself or like, I try on different clothing from different places, it's, it's nice. It's like freeing in a way. (Elena , P.12)

Self-care is important and requires putting yourself first to look after yourself

I just remember thinking they are hurting me more than, staying here is going to hurt more than leaving. So, what's, what's the point in doing something that doesn't work for me? When I could find something else that works for me. (Amber, P. 19).

Self-compassion is about loving yourself through task focused actions.

You see people just, like 'wake up and do your routine and do great and control your mind'. I'm like, come on. How have people got the time for this, to p*** about all morning. Doing all that s*** and putting like 100 things on their face, and having a run like come on. (Tommy, P.4)

Resisting an educational focus on exams

Because they were asking me about my exams and everything and how I think, I said I have no feelings for them. I do not care. If I fail, I fail. If I pass, I pass. I've I've tried my hardest. That's all I care, they said [participant], that is not good enough. You, you will not. I'm not going to accept the fact that you don't care. Everyone has feelings towards their exams. You obviously have an emotion towards them. I really don't. I feel nothing if I think about them. I don't feel anything about them. I'm just happy to leave this place. She said [participant] that's really insulting. (Elena, P.21)

Resisting school

Oh definitely. I don't want to talk to the school. Ever. I will never go back there. (Amber, p.21)

Yeah. I remember once one day I just said to my mum, I can't go back there. And she went ‘okay’. But she'd seen how much was happening, and, she wanted to email but I was too scared for her to tell people… And yeah, so I let her. (Amber, p.18)

Social expectations to say ‘I love myself’ is pretentious

It’s something that pretentious people say, you need to love yourself and wake up in the morning and do star jumps and stuff. (Tommy. P4)

Feeling Understood, Seeking Connection

Cherishing feeling understood; intuitive feeling

It's like. They know, they can feel your feeling. And when you feel stressed they might get a bit stressed. And so you have to be quite calm and gentle with them. Because, they’re quite sensitive as well, to movements and pressure. (Betty, P.24)

CAMHS listens and validates your experience

Because they [CAMHS] actually want to do their job, they're actually here to do their job. They're not here to literally if you say, ‘oh, like I don't like myself’ or something, they're not here to be like, ‘Well, you obviously do because you're still here. You haven't committed suicide.’ Like they're not, they're not here to, like, sort of clap back at you. They actually want to help. (Elena, P. 23)

Finding your supportive community who understands

They've [K-POP band] said before that they can message because I've got like a little chat that you can message them on that they'll like, you can message them about anything and they'll be there for you like there because they've gone through so much, they understand. (Elena, P.31)

One of their concerts, like they they were so they're so like in touch with the world and everything. It's not like they're oblivious. They actually help their fans. And it's not like, oh, you're going through this tough time. Here you go. They actually understand. (Elena, P. 31).

Harmful educational experiences; lack of understanding in school

It's horrible because I had a panic attack once in school and I went to like my head of pastoral. She said you're fine. Just go back to class. I physically cannot breathe. And she said I'm being over dramatic. I should just go. And she has a degree in psychology. May I may I add? And she, she doesn't care. It's just, she works at a secondary school. (Elena, P.21)

School education about mental health as lies

I mean, I did have to Google what it meant. I just it's not like, like in high school. you'd have, like, the occasional, like, assembly about, like, mental health or whatever. You know, they'd be like, and obviously it was complete lies but you'd be like yeah okay whatever, just get through this 15 minutes and now it's like [inaudible 39s]. (Amy p.19)

No, the staff do them weeks where it is like self help week but it's a load of b*******. (Tommy, P.25)

Feeling understood by others, when they consider your own needs

It's just like not many people think about like how you feel or how you are in a situation and things. It's just nice to have someone that will always think about like they know how you are, who you are, and they can take that into consideration. (Sienna, P.5)

Discovering other people experience the same as you

TikTok, it's really good for, everyone says how bad it is. But. It helped me. So… yeah quotes, all of them, everything. A day in the life of being in recovery and all of this… Mental health, all of them, really…There's a girl on there who literally, it's like she's me in another person. It's crazy. She's had practically the same experiences that I've had… I never thought that there were people like me out there. And then seeing other people, it's like, oh my God, there is. And I definitely think it helps to say that I wasn't the only one like this. (Amber, P.3.)

Hiding suffering from peers

No, I don't. I don't really know. I don't. I don't see young people upset, right. People don't like it. And if they do, they're not, like around, like, they're, like, off somewhere, like they're just sitting in the toilet or something. (Amy, P.16)

Reading fiction is a chance to connect with characters who've had similar experiences

I think it's like it's like reading like things and it's like, yeah, it's all, like, very made up. But it's almost it's seeing, like, characters, they almost feel like similar feelings. It's sort of a bit nice because I'm like, well, I'm not the only one who feels like this, like. (Amy, P.9)

It feels delusional to not acknowledge the negatives when can't find any self-positives.

Yeah well it's kinder than just being delusional, and saying that everything's great when it's not. (Tommy , P.13).

CAMHS started to remove the shame and isolation by sharing examples of other people's relatable, negative experiences.

They [CAMHS] made it relatable… just getting some really bad examples of life… they said, is it any worse than that, or something. And I said yeah." (Noah, P. 14.)

Marginalised due to learning difficulties; lack of support from teachers

He would say you should know this. But I have learning difficulties. And Mum told him multiple times. Mum sent emails and emails, even met him in person. And he just wouldn't listen. And everyone, all the other teachers would stick up for him, saying, oh, it's just the way he was teaching. But his teaching should change for the students. (Betty, P.13)

Being held through Suffering and Sharing the Joys

Being alongside suffering

Others sitting with and being patient creates safe spaces to talk.

She just like, lets you take your time. Some people just want you to get it out and just talk to them, but [keyworker] will let you take your time. (Sienna , P.20).

Consistent actions are more trustworthy than words; seeking comfort from others

They're like, well, [pet dog] has this thing that whenever I come home, she, like, wags her tail, gets a teddy. But, like, [pet] really wags her tail. It's like this, and then she wiggles her bum and she can't control her tail. Because she's so excited. And then, like, say if I was going to get upset and I start crying, she would lick my tears away. (Sienna, P. 10)

Sitting with: compassion as sensitivity and tacit understanding

So, they [pet dogs and cats], they might lick away my tears. The cats, they just kind of lie on you. They don't really, like... They'll obviously come over to you and lie on you and show you love, but they can't really, like, do much more. But you know that they're still there to comfort you because they come over and lie on you and it's just nice. (Sienna, P. 11.)

Acknowledging struggles when turning to comforts; recharging energy

I don't know, they just, they just, like, recharge my batteries. It's like, you just sit there and don't need to talk. I'd love, I'd have, if I did get one, trained as a therapy dog, specifically my dog, I'd look after it and everything…I think my mum can [help to feel recharged]. She always gives me a cuddle. She always knows when something is wrong. (Amber, P.29)

Nature offers a space to cry and feel emotion

A little bit yeah. Most people just go there to walk and cry, some people just go there to clear their mind. It's like many different things. Yeah, it's got, what you can do for you. I've done both. Walked around and cried and then walked around and cleared my head, it does wonders. Especially on a sunny day like that. (Noah, P.5)

Having no-one to listen led to expressions of pain through self-harm (hitting walls).

But at the same time it was just too late I couldn't, change, it's the way that they were trying to help me. I couldn't learn. I couldn't adapt. I tried everything. I tried meditation, counting to 10, breathing, screaming into your pillow, punching your pillow. Burning your thoughts, writing them down, sending them into the sky. Skimming a rock off water or something you know, just like staring into the sunset. It didn't do anything….Yeah. That's all it takes, just someone to listen. I think it helps someone. (Noah, P.12).

Fear of judgement blocks connection to others, whereas it feels safe to be comforted by his dog who can't judge him.

Like, the other day I lost the plot, broke down, self-harmed, and my dog wouldn't leave my side lost until I was all right, she was just next to me. (Noah, P.28)

She just sits there and looks at me like, turns her head. It's really cute. She lifts the side of her ears up. (Noah, P.29.)

Comforts during suffering

I've got a dog. I've had him since he was 8 and he's 10 now, yeah since he was a puppy and he is my best friend. He's like my therapy dog. Whenever I get really panicky, he sits on my lap and just hugs me until I calm down. Very protective of me as well. (Betty, P.25)

Compassionate creatures: an intuitive understanding of feeling

Dogs. Bearded dragons. Like snakes as well, they're like, more not spiky but, and I used to own, well my dads side, we don't talk about him, he used to own two. And they were the most lovely creatures ever. I really want one. Cats are cuddly. Horses, horses are one of the most feeling creatures ever. They are very good at, like therapy animals, they are therapy animals, they are the most loving creatures as well. And very connecting… I used to do horse riding and even though the lessons were stressful, riding the horses were absolutely calming. Just grounding. It was beautiful. (Betty, P. 23).

Cherishing sensitive and attuned spaces

I don't know how to explain it. It just felt, nice. They're [horses] very trusting. I mean, there's a person on your back, they're going to jump you. You know what I mean? They've got to be very trusting, but then it's not, like forcefully trust. It's like. They know, they can feel your feeling. And when you feel stressed they might get a bit stressed. And so you have to be quite calm and gentle with them. Because, they're quite sensitive as well, to movements and pressure. (Betty, P.24)

Difficult to create space for self-compassion because you need to prioritise college demands over difficult feelings.

I think like when we have like time off from my college and that and I've got like time to relax from that. It's a bit easier then because like there's less going on. So I think sometimes it's like, it's like, if I'm having a bit of a difficult time. What am I gonna pick? Because, yeah. And then you just because like, going tomorrow like, I can't be going

tomorrow and saying I'm struggling because they'll just be like you need to do the work. (Amy, P.25)

Animals 'sit alongside' your suffering, non-judgementally whereas peers might judge you.

He's not going to judge me. He's not gonna start talking going ' that's embarassing'. Like he might look at me a bit funny, but like. Like, erm, my auntie has loads of like dogs and that so it's quite frequently, like if I'm ever upset with them, they'll just lick my face, which is really disgusting, but, they will flick my face and I go. This is really nice guys, but, get off [laughs]. (Amy, P.17)

It's rare and special to find someone who understands you

If I'm sad, he'll just like let me talk about it and just listen. And then he'll like reassure me about everything and then give me a hug and then put on my favourite show. Get me some food. (Sienna, P.6)

Sharing laughter, playfulness and joy

Emotional warmth and comfort with loved ones.

We just like, we just laugh or just watch a movie or something. It's just fun. It's just nice to spend time with him [participant's father]. (Sienna , P.2)

Because it just reminds me of everything with my granddad. My granddad's, like, the happiness of my life when I was a kid. I really cherish him. (Sienna , P. 8)

Relating self-compassion to memories of happiness in the company of other people.

I think it has to be the days that my aunt did with us. It was always one day in the six weeks holidays. We do this thing every year called an auntie and nephews day, me and my two cousins. We'd go out and just spend a whole day with her doing anything. (Elena , P.2)

No, she was fine. Me and my other cousin, we were laughing our heads off. But then my oldest cousin, she was she, she was laughing but she kept on asking about is she OK? But she just lay there just brawled out on the trampoline. (Elena , P.2)

Playfulness helping to forget distress

I think it's just her whole personality. When you're with [dogs name], like she kind of gets what it's like, and she gets bity. You don't like it…. You get quite sad with it because it hurts, but when she's playful like she's not biting and like, she actually gives you kisses and everything, you kind of just forget with everything. You kind of just forget about everything, she's just so cute and just, you just forget about everything. (Elena, P. 32)

It's helpful having a friend to problem solve with and laugh about problems with.

Laughing brings the mood up.

Yeah, I was just like, that's so awful. But yeah, it's just funny because it's just like, yeah, it that's just sort of like a big thing. Like someone I can just laugh with. Because like, the key to, like, I don't want to just like, be really serious. It's just nice to laugh really. (Amy, P.20)

The innocence of playfulness is comforting, as a reminder that good things exist

Just put a smile on my face. Watching her [pet dog] play, the innocence of it all. (Noah, P.15)

Ways of Treating Each Other, and Ourselves

Self-compassion perceived as taking care of oneself, but you need the motivation to do that.

I just can't be arsed and that's my choice. Like people run to be healthy and I'm like, that's fair enough, but I can't be arsed. But I'd probably be happier, but I can't be arsed to do anything. (Tommy, P. 5)

I dunno just try do things that are good for your health like eat right, and run and try not to worry. I can't figure that out but. (Tommy, P.22)

Self-care is more than looking after your body, it sparks joy/is a passion

I guess from Tiktok and social media, yeah. And I've just got a passion for it. And my mom used to do nails as well. So she'd do them for us. And then I learned how to do them myself. And I love doing them. I've done like Poly-gel and stuff like that. But yeah (Amber, P.1)

Too tired to self-care when burnt out, loss of interest

It feels good. I mean a few months ago when I burnt out it went. I lost everything. I wouldn't do anything. I was just so tired and ever since then it's slowly been getting a bit better. Like it's not as tiring to wash my hair or to do anything. But yeah, it does take time for it to come back. And yeah. (Amber, P.1)

Be Grateful for your health, it could be lost

Hmm, don't, like, take things for granted. Don't take the happiness for granted. You have to make sure you're always looking after yourself. (Sienna, P. 3)

Physical and mental self-care

Mmm depends what way, like, if it's care on my skin, then it's, like, skincare, make sure you're cleaning my face all the time, because, like, it can really affect it. (Sienna. P. 4)

Taking care of yourself. Physically, mentally. Taking care of yourself about everything that you can. (Sienna, P.10)

Actively keeping yourself healthy

Keep healthy, keep your mind healthy. Just that. Be kind to other people as well. Because that can bring a lot of happiness to yourself as well. (Betty, P. 17)

Be kind to yourself. And treat yourself as a person…Take care of yourself and trust in yourself, believe in yourself. (Betty, P.18)

Compassionate and kind sister – tuning into her likes and needs

That sister is always very kind. She's very, like, compassionate and understanding. And she's set up this thing because I don't go to school anymore. I do home schooling, every week I got to hers. And we have a craft afternoon. Which is nice and peaceful. She lives with her three dogs. (Betty, P.19)

Receiving unexpected acts of kindness from others

Once I was waiting for Mom outside there, and it was storming and raining and the Priest, Chaplain, I still don't know which one, and he got me in, told me to come in and he got me a drink and stood me by the candles to warm up my body. (Betty, P.8)

Planning ahead with soothing ideas for moments of suffering

I mean one of these is like I do like to make a soothe box. I do like making them so I have it's like pair of comfy pyjamas, easy snacks to eat and easy movies that you've already watched (Amber, P.6)

Feeling cared for by others, when they consider your own needs

If I'm like over stimulated, he'll [boyfriend] like brush my hair. (Sienna, P.5)

Modelling compassion to others and self

Yeah, it's like. He (Granddad) was just really understanding, yeah, and understanding to himself. Yeah. Whatever he was giving out, he would also give it to himself. So he always made sure that as much as he's looking after his family, he will also make sure that he's okay too. (Sienna, P. 14)

A cosy and calming environment for self-care

It's only them. So it's quiet and she's got cosy decorating. She likes twinkling lights, and pink and books and blankets. It's just nice. (Betty, P.19)

Taking care of your mental health being modelled

That sister is always very kind. She's very, like, compassionate and understanding. And she's set up this thing because I don't go to school anymore. I do home schooling, every week I got to hers. And we have a craft afternoon. Which is nice and peaceful. She lives with her three dogs. (Betty, P.19)

Learning from his mum, that taking care of others is an act of kindness to oneself.

My mom? Yeah. She takes care of the dog. Me, my sister. She's always there for us. Same thing goes for my sister. (Noah, P.19)

Self-compassion links to caring for other people

As long as I can help someone else and redeem myself in that way, it feels like I'm doing something worthwhile, even though it feels like I'm never going to be redeemed for it…my self-compassion is to help other people. (Noah, P.5)

Self-sacrificial care, putting other people first

I'm always a big person and care about other people. I've always said to my family and my friends, that I'd go to prison for them. If someone's struggling, I aint going to sit there a [inaudible] away from it, I'll be there. (Noah, P.5)

Feels better about himself when protecting his family, which is the opposite action to where his feeling of shame originated

I've done a lot of things that I wasn't proud of when I was living with my mom. And I hate myself every day for it, and as long as I can help someone else and redeem myself in that way, it feels like I'm doing something worthwhile, even though it feels like I'm never going to be redeemed for it. (Noah, P.8)

Care about yourself, don't pay attention to other people's judgements

OK, I don't care what people think of me. I really don't. I've spent my whole primary school life and half my high school life thinking why should I give a shit about what other people think about me. You shouldn't. As long as you care about yourself. That's it. Don't listen to what everyone else says. Cause at the end of the day. They're probably saying it cause they've got something wrong with them. It's true. (Noah, P.32)